

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12000 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury						c. LENGTH OF STAY IN 1b 3 Days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital						d. STREET ADDRESS Mardela					
3. NAME OF DECEASED (Type or print) First Lula Middle Elizabeth Last Adkins						4. DATE OF DEATH Month August Day 13 Year 19 66					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 19/1886		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired County School Teacher						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Mardela (Wicomico Co) Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Edward Wright						14. MOTHER'S MAIDEN NAME Emma Holloway					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-07-7032		17. INFORMANT Robert L. & Carroll W. Adkins (Sons) Address Salisbury Md. - Mardela, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hypertension DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 6 Weeks 15 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 8/10/66 , 19 66 , to 8/13/66 , 19 66 , that (I) (we) last saw the deceased alive on 8/13/66 , 19 66 , and that death occurred at 8:50 M, from the causes and on the date stated above.											
22a. SIGNATURE Charles H. Winnacott						A.M. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-13-66			
22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott, M.D.						22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 16/1966		23c. NAME OF CEMETERY OR CREMATORY Mardela Mem. Cemetery (Old Sect.) Mardela, Md.		23d. LOCATION (City, town or county) (State)		25a. REC'D BY REGISTRAR AUG 16 1966			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge					
HOLLOWAY & COMPANY SALISBURY, MARYLAND											

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Nov. 1948

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN lb BERLIN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING HILL NURSING HOME		d. STREET ADDRESS S. MAIN ST	
3. NAME OF DECEASED (Type or print) First Middle Last ROLAND W. BEAUCHAMP		4. DATE OF DEATH Month Day Year AUG 14 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 30, 1902
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days 14 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POULTRY FARMER		10b. KIND OF BUSINESS OR INDUSTRY FEEDING POULTRY	
11. BIRTHPLACE (County & State, or foreign country) BERLIN, WORCESTER, M.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES S. BEAUCHAMP		14. MOTHER'S MAIDEN NAME SALLIE MARTHA HASTINGS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. R. W. BEAUCHAMP		Address BERLIN MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary + cerebral, arterio (c) sclerotic		INTERVAL BETWEEN ONSET AND DEATH Months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Parkinsonism - severe			
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 66 , to 5/10 , 19 66 , that we last saw the deceased alive on 5/10 , 19 66 , and that death occurred at 7:25 AM , from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 8-18-66	
22c. PHYSICIAN'S NAME (Type) Oswald J. Burton, M.D.		22d. ADDRESS MEDICAL CENTER, SALISBURY, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/16/66	23c. NAME OF CEMETERY OR CREMATORY ST. PAULS CHURCHYARD	23d. LOCATION (City or Town) (County) (State) BERLIN WOR. MD
24. FUNERAL DIRECTOR Anna A. Burdette Berlin Md		25a. REC'D BY REGISTRAR AUG 22 1966	
		25b. REGISTRAR'S SIGNATURE [Signature]	

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WALL ST. NEW YORK

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FOR STATE
HEALTH DEPT.

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MARYLAND DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301-W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11998

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY in 1b 27 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 163 OCEAN CITY RD.				d. STREET ADDRESS 163 OCEAN CITY RD.			
3. NAME OF DECEASED (Type or print) HELEN JONES BENSON				4. DATE OF DEATH AUGUST 23, 1966			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APR. 25, 1906	
9. AGE (In years last birthday) 60 Yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HARRY JONES				14. MOTHER'S MAIDEN NAME MAE E. CATLIN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 217-16-9524			
17. INFORMANT J. LEE BENSON				Address SEE 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis Ruptured Gastric ulcer 501 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer				DATE SIGNED 8-25-66			
EXAMINER'S NAME (Type) EARL L. ROYER M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 8/25/1966		22c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY	
22d. LOCATION (City, town, or country) (State) SALISBURY, MARYLAND							
23. FUNERAL DIRECTOR George C. Hies				ADDRESS SALISBURY, MARYLAND			
24a. REC'D BY REGISTRAR AUG 29 1966				24b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Item 2 from birth cert. **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u> ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>23 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		e. STREET ADDRESS <u>3 Dorchester St.</u>	
3. NAME OF DECEASED (Type or print) First <u>JAMES B. BREWER</u> Middle <u>BRASHER</u> Last <u>BRASHER</u>		4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1966</u>
9. AGE (in years last birthday) yrs. <u>2</u> Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>SALISBURY MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LARRY BRASHER</u>		14. MOTHER'S MAIDEN NAME <u>KATE JONES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>LARRY BRASHER</u>		Address <u>Ocean City MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage (basilar)</u> 7605 DUE TO (b) <u>Perinatal Hypoxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>76 hrs (approx)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Prematurity (Birth wt 2345 gms)</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>8/4</u> , 19 <u>66</u> , to <u>8/7</u> , 19 <u>66</u> , that (II) (we) last saw the deceased alive on <u>8/6</u> , 19 <u>66</u> , and that death occurred at <u>3:30</u> AM, from the causes and on the date stated above.	
22a. SIGNATURE <u>Arfred C. Kolls</u> M.D.		22b. DATE SIGNED <u>8/7/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Medical Center Salisbury Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/4/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>		23d. LOCATION (City, town or county) (State) <u>BERLIN MD</u>	
24. FUNERAL DIRECTOR <u>Anna A. Burdage</u>		25a. REC'D BY REGISTRAR <u>—</u>	
25b. REGISTRAR'S SIGNATURE <u>—</u>		DATE <u>AUG 10 1966</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12004 CERTIFICATE OF DEATH 12000

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parsonsborg</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parsonsborg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.D. #1</u>		d. STREET ADDRESS <u>R.D.#1</u>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Martha</u> Last <u>Brittingham</u>		4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1906</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>25</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Powellville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Edith Powell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>213-42-2296</u>	
17. INFORMANT <u>Mrs. Mary Morris (daughter)</u> <u>Rt. 1, Parsonsborg, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma metastasized to intestines</u> 1992 DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>8-20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-18</u> , 19 <u>66</u> , and that death occurred at <u>7P</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank Lewis</u>		22b. DATE SIGNED <u>8/22/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Frank Lewis</u>		22d. ADDRESS <u>Willards, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 23, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>AUG 24 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE	

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CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>SOMERSET</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE RT 1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL Hospital</u>						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) <u>EDWARD D. BROWN</u>						4. DATE OF DEATH <u>August 23 1966</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-18-1920</u>		9. AGE (In years last birthday) <u>46 yrs.</u>		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MASONRY</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Somerset MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN BROWN</u>						14. MOTHER'S MAIDEN NAME <u>HELEN LEATHERBURY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>1942-45</u>				16. SOCIAL SECURITY NO. <u>218-144273</u>		17. INFORMANT <u>BETTY BROWN - PRINCESS ANNE</u>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> 7xvi DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/23, 1966</u> , to <u>8/23, 1966</u> , that (I) (we) last saw the deceased alive on <u>8/23, 1966</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Hand J. Schure</u>						M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)						22b. DATE SIGNED					
22d. ADDRESS											
23a. BURIAL CREMATION REMOVAL (Specify)				23b. DATE THEREOF <u>8/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Opiko Rd Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Princess Anne Somerset Md</u>			
24. FUNERAL DIRECTOR <u>Walter West</u>						ADDRESS <u>Salisbury</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE	
						DATE <u>AUG 29 1966</u>					



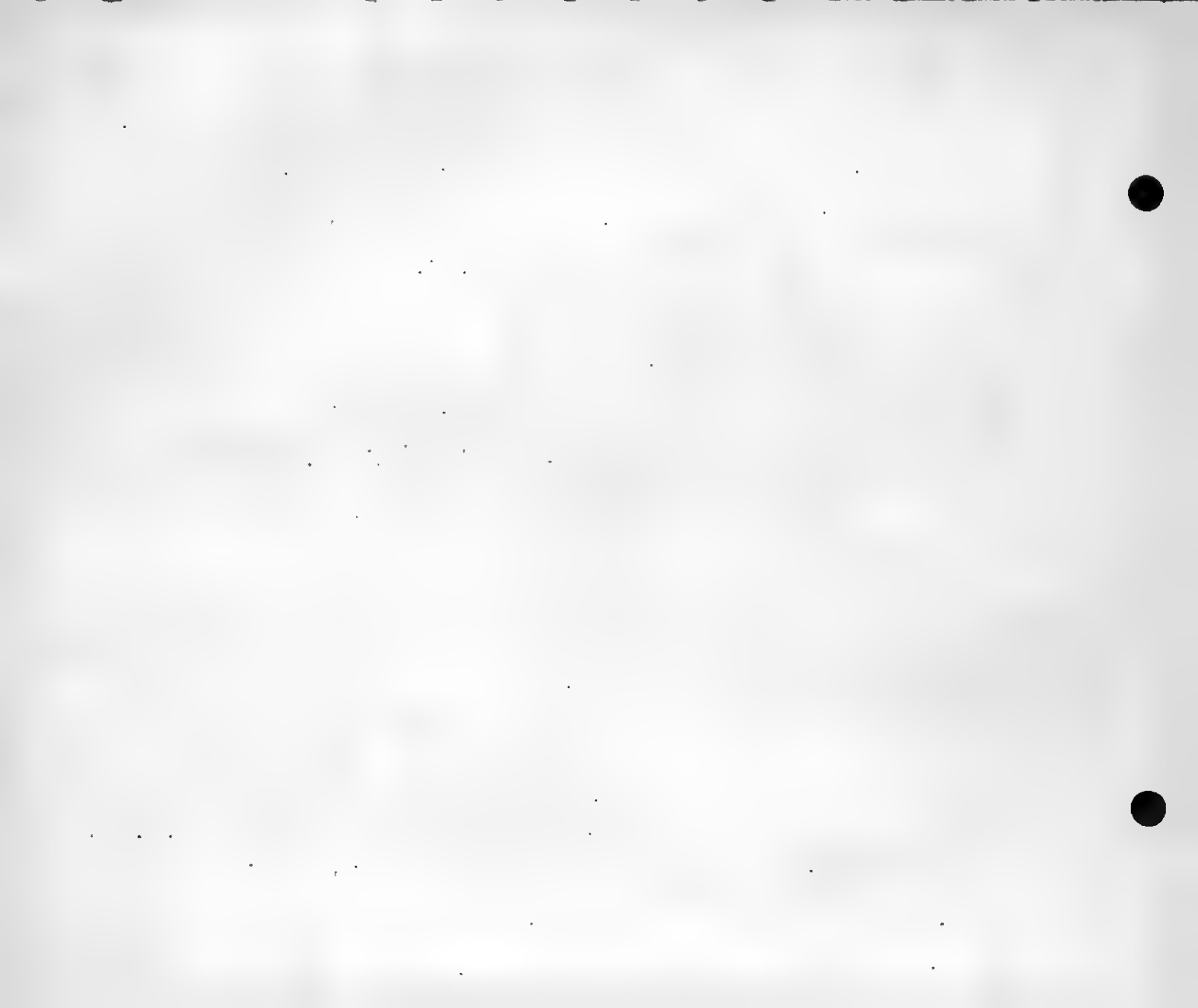
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BPP

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 12005 CERTIFICATE OF DEATH 12002									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 225 Maryland Avenue				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital D.O.A.					d. STREET ADDRESS Salisbury, Maryland			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN		Middle ALBERT		Last BROWN		4. DATE OF DEATH Month August		Day 12	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1884		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John Brown					14. MOTHER'S MAIDEN NAME Virginia Parker				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-46-4394-T		17. INFORMANT Mrs. Lucy J. Brown (Wife) 225 Maryland Ave., Salisbury, Maryland			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3-7</u> , 19 <u>64</u> , to <u>8-13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-13</u> , 19 <u>66</u> , and that death occurred at <u>8:4</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Wilbur R. Ellis</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED Aug. 13, 1966	
22c. PHYSICIAN'S NAME (Type) Dr. Wilbur R. Ellis					22d. ADDRESS Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 15, 66		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town or county) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR AUG 16 1966 DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS		g. DATE OF DEATH		h. MONTH		i. DAY	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO (b)		DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-14, 1966, to 8-21, 1966, that (I) (we) last saw the deceased alive on 8-20-1966, and that death occurred at 5:40 A.M. from the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		23e. (State)		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		24c. DATE		24d. TIME		24e. PLACE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
12008						CERTIFICATE OF DEATH			12004				
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>						d. STREET ADDRESS <u>305 Cedar Drive</u>							
3. NAME OF DECEASED (Type or print) First <u>Hance</u> Middle <u>Junior</u> Last <u>Caldertv</u>						4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1966</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 2, 1966</u>		9. AGE (in years last birthday) <u>0</u> yrs. <u>0</u> months <u>0</u> days <u>0</u> hours <u>17</u> min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Maryland</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Hance Junior Calder</u>						14. MOTHER'S MAIDEN NAME <u>Rose Mary Dryden</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>N/A</u>							
17. INFORMANT <u>Mr. Hance J. Calder, 305 Cedar Drive Salisbury, Maryland</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia, prematurity</u> DUE TO (b) <u>Uterine Placenta</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Gladys M. Allen</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug 2, 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>Dr. Gladys M. Allen</u>						22d. ADDRESS <u>224 N. Division St. Salisbury, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)							
<u>Burial</u>		<u>Aug. 4, 1966</u>		<u>Wicomico Memorial Park</u>		<u>Salisbury, Maryland</u>							
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY SALISBURY, MARYLAND</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
DATE <u>AUG 4 1966</u>													



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

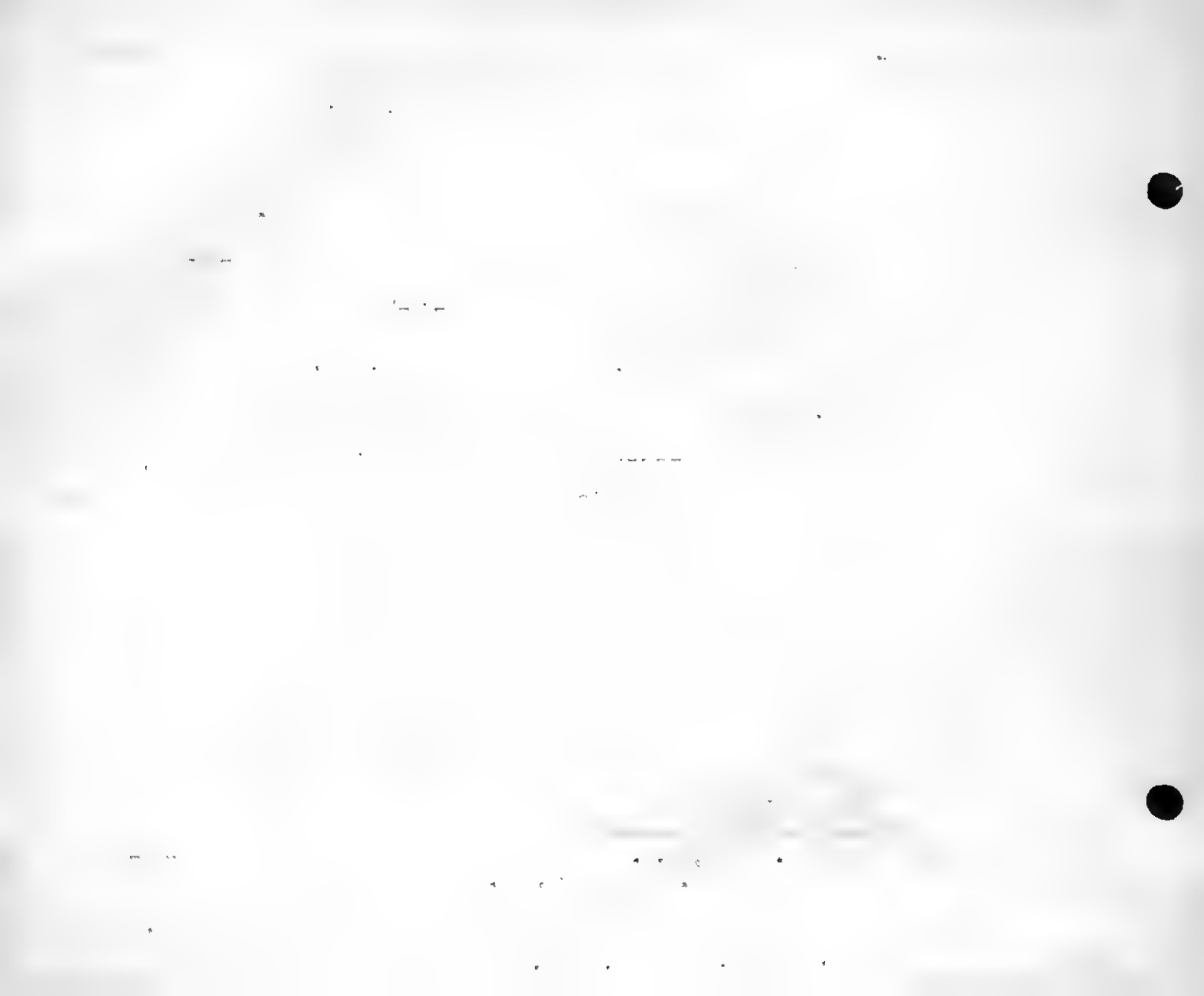
VR A15ME (5)
GM 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #95 0 8/24/66 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Delmar	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 107 Pine St.	
3. NAME OF DECEASED (Type or print) Lillie M Calhoun		4. DATE OF DEATH Month 8 Day 15 Year 66	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years (irthday) yrs) 79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Delmar, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel J. Adams		14. MOTHER'S MAIDEN NAME Amelia Elliott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mary McClaine, Delmar, Md.		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 5721 Candidons, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET OF ILLNESS AND DEATH hours hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md.		22. DATE SIGNED 8-17-66	
23a. BURIAL, CREMATION, or OTHER DISPOSAL (Specify) Burial	23b. DATE THEREOF 8-18-66	23c. NAME OF CEMETERY OR CREMATORY St Stephens	23d. LOCATION (City or town) (County) (State) Delmar, Del.
24. FUNERAL DIRECTOR Charles W. Marvel, Delmar, Del.		25. REGISTRATION BY REG. STRAR AUG 19 1966	
26. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12010

CERTIFICATE OF DEATH

12006

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 7 Days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grasonville		d. STREET ADDRESS 17 ?		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Welford G. Carter		4. DATE OF DEATH Month Day Year 8 15 19 66		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/10/1897		9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR Months Days Hours Min. 15 00 00 00		11. IF UNDER 24 HRS Hours Min. 00 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10b. KIND OF BUSINESS OR INDUSTRY HAULING		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME RICHARD Smoot		14. MOTHER'S MAIDEN NAME CATHERINE CARTER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-14-4442		17. INFORMANT WELFORD CARTER Address Chester Town, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritoneal Abscess DUE TO (b) Postoperative Cholecystectomy DUE TO (c) Chronic Cholecystitis - Necrotic CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														INTERVAL BETWEEN ONSET AND DEATH 2 weeks					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cholecystitis																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 8/8 , 19 66 to 8/15 , 19 66 , that (I) (we) last saw the deceased alive on 8/15 , 19 66 , and that death occurred at 7:00 P.M. from causes and on the date stated above																			
22a. SIGNATURE C. H. Winnacott								M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 8/16/66							
22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M. D.								22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 8/20/1966				23c. NAME OF CEMETERY OR CREMATORY JOSHUA CEMETERY				23d. LOCATION (City or Town) (County) (State) R.F.D. Chester Town, Md							
24. FUNERAL DIRECTOR Zemelt, Daley								ADDRESS CHESLETOWN, MD				25. REC'D BY REGISTRAR AUG 18 1966				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12011						12007					
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Delaware</i> b. COUNTY <i>Sussex</i> ✓					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>						d. STREET ADDRESS <i>R2 Whitesville Road</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>L.</i> Last <i>Casson</i>			4. DATE OF DEATH Month <i>August</i> Day <i>16</i> Year <i>1966</i>			5. SEX <i>Male</i>			6. COLOR OR RACE <i>White</i>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>Jan. 3, 1901</i>			9. AGE (In years last birthday) <i>65</i> yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>own farm</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Tennessee</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John C. Casson</i>						14. MOTHER'S MAIDEN NAME <i>Isabel Jones</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>195 105 8791</i>		17. INFORMANT <i>Mrs. Laura B. Casson</i>			Address <i>r2 Laurel, Del.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Insufficiency</i> <i>IC3X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of lung with metastases</i> (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <i>8/15</i> , 19 <i>66</i> , to <i>8/16</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/16</i> , 19 <i>66</i> , and that death occurred at <i>5:30</i> AM, from the causes and on the date stated above.											
22a. SIGNATURE <i>Richard E. Hughes</i>						22b. DATE SIGNED <i>8/19/66</i>			22c. PHYSICIAN'S NAME (Type) <i>Richard E. Hughes</i>		
22d. ADDRESS <i>Laurel, Del.</i>						22e. REC'D BY REGISTRAR <i>Charles</i>			22f. REGISTRAR'S SIGNATURE <i>Charles</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>8/19/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Stephens Cem</i>			23d. LOCATION (City, town or county) (State) <i>Delmar, Delaware</i>		
24. FUNERAL DIRECTOR <i>W. J. Dickerson</i>						25. REC'D BY REGISTRAR <i>Charles</i>					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15MF
6M 1/66

12012

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12008

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville		c. LENGTH OF STAY IN 1b Pittsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Richardson Camp		d. STREET ADDRESS Richardson Camp	
3 NAME OF DECEASED (Type or print) First Middle Last BETTY CHASE		4 DATE OF DEATH Month Day Year 8-25-66 19	
5 SEX F	6 COLOR OR RACE AA	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-15-1927
9 AGE (In years last birthday) 39 yrs		10 UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tomato peeler		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Laurel Del.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17. INFORMANT Duke Rhinzen - Pittsville Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cellulitis, left breast DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 48 hours 11 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Scratched left breast on door at home.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8-14-66 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Own home	20f. (City or town) (County) (State) Pittsville, Wicomico, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		22. DATE SIGNED August 26, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-28-66	23c. NAME OF CEMETERY OR CREMATORY Evergreen	23d. LOCATION (City or town) (County) (State) Berlin Wic. Md.
24. FUNERAL DIRECTOR Donation Jolley, Salisbury, Md.		25a. REC'D BY REGISTRAR DATE SEP 6 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> 12013 <div style="border: 1px solid black; border-radius: 50%; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center; margin: 5px;">M</div> </div> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> <div> 12009 </div> </div>													
1. PLACE OF DEATH, COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BERLIN							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BERLIN				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL Hospital						d. STREET ADDRESS OAK LANE							
3. NAME OF DECEASED (Type or print) First T. Middle J. Last CLEVELAND						4. DATE OF DEATH Month August Day 18 Year 1966							
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-9-13		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME L. M. CLEVELAND						14. MOTHER'S MAIDEN NAME FANNY CLEVELAND							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 259-16-2885		17. INFORMANT JOETTER CLEVELAND - BERLIN, MD							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from chronic gastric ulcer DUE TO ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left sided Paralysis -												INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Aug 6 1966 to Aug 18 1966 , that (I) (we) last saw the deceased alive on Aug 18 1966 , and that death occurred at 4:40 PM , from the causes and on the date stated above.													
22a. SIGNATURE Robert T. Adkins						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 20 Aug 66					
22c. PHYSICIAN'S NAME (Type) ROBERT T. ADKINS						22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-21-66		23c. NAME OF CEMETERY OR CREMATORY ANTIOCH CEMETERY				23d. LOCATION (City, town or county) (State) FRANKFORD - DELA.					
24. FUNERAL DIRECTOR Cl. Kough's Nelson, Frankford, Del.						25a. REC'D BY REGISTRAR AUG 26 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge					



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1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Enoch</u> First <u>ELIJAH</u> Middle <u>Collins</u> Last 4. DATE OF DEATH <u>August 31</u> 19 <u>66</u>					5. SEX <u>MALE</u> 6. COLOR OR RACE <u>NEGRO</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>12/16/1900</u> 9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>					13. FATHER'S NAME <u>Irvin Collins</u> 14. MOTHER'S MAIDEN NAME <u>Gertrude ?</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Frank Collins, Middletown, Dalaware</u> Address					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Myocardial Infarction</u> 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) <u>Coronary Artery Disease</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obstructive Pulmonary Disease, Chronic Bronchitis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					21. I certify that (I) (this hospital) attended the deceased from <u>30 August, 1966, to 31 Aug., 1966</u> that (I) (we) last saw the deceased alive on <u>31 Aug., 1966</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>D.M. Bouie</u> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9/3/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt Hope AMEZ</u> 23d. LOCATION (City, town or county) (State) <u>Princess Anne, Md</u>					24. FUNERAL DIRECTOR <u>William H. James Jr. Princess Anne, Md</u> 25a. REC'D BY REGISTRAR <u>SEP 7 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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169

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12015

12011

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MD d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 417 PENNA. AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Houston Quinn Coulter		4. DATE OF DEATH Month August Day 3 Year 1966		5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 12, 1912		9. AGE (If years last birthday) 54 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GRADER OPER. CONSTRUCTION				10b. KIND OF BUSINESS OR INDUSTRY INDIANA				11. BIRTHPLACE (County & State, or foreign country) INDIANA				12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME JEFFERY COULTER						14. MOTHER'S MAIDEN NAME COCA QUINN							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1938-1941				16. SOCIAL SECURITY NO. 1938-1941		17. INFORMANT MRS. MARY M. COULTER Address 417 PENNA AVE Salisbury Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding esophageal varicose DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Decompensative hepatic cirrhosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 7-12 , 1966, to 8-3 , 1966, that (I) (we) last saw the deceased alive on 8-3 1966 and that death occurred at 8 PM , from the causes and on the date stated above.													
22a. SIGNATURE James H. Cofford						22b. DATE SIGNED 8/3/66		22c. PHYSICIAN'S NAME (Type) Medical Center Salisbury Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 8-5-1966		23c. NAME OF CEMETERY OR CREMATORY PARSONS CEM.		23d. LOCATION (City, town or county) (State) SALISBURY MD.					
24. FUNERAL DIRECTOR Thomas F. Wallace Thomas F. WALLACE Salisbury Md.						25a. REC'D BY REGISTRAR DATE AUG 5 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge					

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>23-2</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>		d. STREET ADDRESS <i>R.F.D. #2</i>	
3. NAME OF DECEASED (Type or print) <i>Bertha H DAVIS</i>		4. DATE OF DEATH Month <i>August</i> Day <i>16</i> Year <i>1966</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov 16 1889</i>	
9. AGE (In years last birthday) <i>75 yrs.</i>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <i>1</i> Days <i>5</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>A. Calvin Hottenstein</i>		14. MOTHER'S MAIDEN NAME <i>Ada Rhodes</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>216 40 3555</i>	
17. INFORMANT <i>Mrs. Madge Westfall</i>		Address <i>Snow Hill, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic CA rectum</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>16 wks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>6/27, 1966</i> to <i>8/16, 1966</i> , that (I) (we) last saw the deceased alive on <i>8/16</i> 19 <i>66</i> , and that death occurred at <i>3:30</i> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>W. P. Sadler</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>W. P. Sadler MD</i>		22d. ADDRESS <i>Medical Center Salisbury MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8-18-66</i>	
23c. NAME OF CEMETERY OR CREMATORY- <i>Bates Methodist</i>		23d. LOCATION (City, town or county) (State) <i>Snow Hill, Maryland</i>	
24. FUNERAL DIRECTOR <i>Norman F. ...</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>AUG 22 1966</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR #15 (4)
20M 1/65

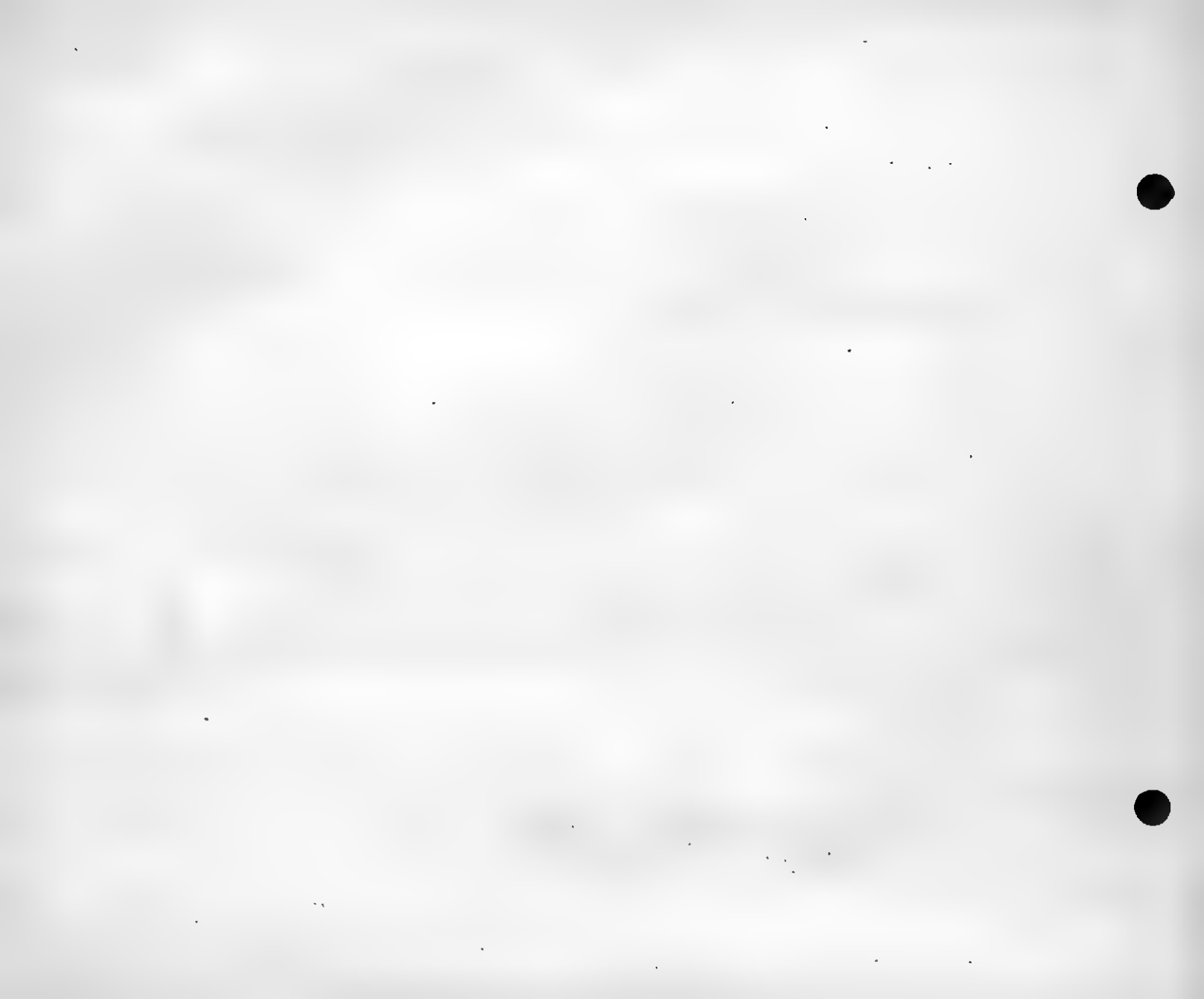
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12017

CERTIFICATE OF DEATH

12013

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS Record St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret M. DAVIS		4. DATE OF DEATH AUGUST 21 1966	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 26 1904
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Sewing room	
11. BIRTHPLACE (County & State, or foreign country) Pittsville Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Artie W. Campbell		14. MOTHER'S MAIDEN NAME Ellis M. Nichols	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218 016304	
17. INFORMANT Wm. A. Davis		Address 640 South Ave. Secane, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4011 Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Failure (c) 2 mo			INTERVAL BETWEEN ONSET AND DEATH 2 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-21, 1966 to 8-21, 1966 that (we) last saw the deceased alive on 8-21 1966 and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE William B. Smith		22b. DATE SIGNED 8-21-66	
22c. PHYSICIAN'S NAME (Type) William B. Smith		22d. ADDRESS Attending Phys. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-24-66	
23c. NAME OF CEMETERY OR CREMATORY Dale Cemetery		23d. LOCATION (City, town or county) (State) Whaleyville Maryland	
24. FUNERAL DIRECTOR Erman F. Morris, Snow Hill, Md.		25a. REC'D BY REGISTRAR AUG 24 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
12017		12014							
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 1000 E. 1st St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ROBERT			First Middle Last DAVIS			4. DATE OF DEATH Month Day Year AUGUST 30 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/18/21		9. AGE (In years last birthday) 45 yrs. 5 Months 9 Days 9 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Nelsonville, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Davis					14. MOTHER'S MAIDEN NAME Virginia Justice				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 222-05-3885		17. INFORMANT James H. Davis Address 1000 E. 1st St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma DUE TO (b) _____ (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST, (a) _____ (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH 18 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from July 13, 1966 to Aug 30, 1966 , that (I) (we) last saw the deceased alive on Aug 30, 1966 , and that death occurred at 3:15 M, from the causes and on the date stated above.									
22a. SIGNATURE Thomas C. Hill Jr.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED August 30, 1966		
22c. PHYSICIAN'S NAME (Type) Thomas C. Hill Jr.					22d. ADDRESS Pine Bluff Road, Salisbury, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/13/66		23c. NAME OF CEMETERY OR CREMATORY C.M. E.		23d. LOCATION (City, town or county) (State) Wicomico, Md.			
24. FUNERAL DIRECTOR William Berzoff, Wilford, Del.					ADDRESS		25a. REC'D BY REGISTRAR SEP 2 1966		
							25b. REGISTRAR'S SIGNATURE Charles Judge		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

12019

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12015

1 PLACE OF DEATH a COUNTY Wicomico <i>md</i> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1		d STREET ADDRESS Route # 1	
3 NAME OF DECEASED (Type or print) Carrie Deshields		4 DATE OF DEATH 8-1-66	
5 SEX F	6 COLOR OR RACE C	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1898
9 AGE (In years last birthday) 68 yrs		10 IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min 19	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b KIND OF BUSINESS OR INDUSTRY none	
11 BIRTHPLACE (State or foreign country) md		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME unk		14 MOTHER'S MAIDEN NAME unk	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unk		16 SOCIAL SECURITY NO unk	
17 INFORMANT James Deshields		Address unk	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 9 m pm 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) Buried		23b DATE THEREOF Aug 5-66	
23c NAME OF CEMETERY OR CREMATORY Tyngton Cem		23d LOCATION (City or Town) (County) (State) Tyngton md	
24 FUNERAL DIRECTOR Borber MD Wash		25a REC'D BY REGISTRAR AUG 8 1966	
25b REGISTRAR'S SIGNATURE J Charles Judge		22. DATE SIGNED 8-1-66	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #7, 8 & 9 only #33-0 8/26/66 pc

12070

CERTIFICATE OF DEATH

12016

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 218 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		d. STREET ADDRESS RFD #3	
3 NAME OF DECEASED (Type or print) First Thomas Middle Henry Last Fitzgerald		4 DATE OF DEATH Month 8 Day 17 Year 19 66	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 16, 1887
9. AGE (In years last birthday) yrs. 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER	
11 BIRTHPLACE (County & State or foreign country) MONIE, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS HENRY FITZGERALD		14. MOTHER'S MAIDEN NAME GEORGIA WALLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT MRS. ANNA LOIS LEWICK		Address DAMASCUS, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA DUE TO (b) BRONCHOGENIC Carcinoma Lung DUE TO (c) with extensive metastases		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Arteriosclerosis - (H); Osteoarthritis		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/11 , 19 66 , to 8/17 , 19 66 , that (I) (we) last saw the deceased alive on 8/17 , 19 66 , and that death occurred 06:05 P.M. from causes and on the date stated above			
22a. SIGNATURE C. H. Winnacott		22b. DATE SIGNED 8/18/66	
22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 8/21/1966	
23c NAME OF CEMETERY OR CREMATORY ST. ANDREW CEMETERY		23d. LOCATION (City or Town) (County) (State) PRINCESS ANNE, MD.	
24 FUNERAL DIRECTOR LEVIN R. WILSON		25a. REC'D BY REGISTRAR AUG 23 1966	
ADDRESS HOMER, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR #15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12021					12017				
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>					d. STREET ADDRESS <i>224 Newton Street</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Elaine</i>		Middle <i>Elizabeth</i>		Last <i>Foust</i>		4. DATE OF DEATH Month <i>August</i>		Day <i>9</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>January 10, 1888</i>		9. AGE (In years last birthday) <i>78</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>6</i> Days <i>29</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <i>Deal Island, Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Eldridge Windsor</i>					14. MOTHER'S MAIDEN NAME <i>Mary Webster</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>497-14-7471-B</i>		17. INFORMANT Address <i>Edward Eugene Foust (Husband) 224 Newton St., Salisbury, Maryland</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>4281</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <i>12 hr.</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>generalized atherosclerosis</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>7/15</i> , 19 <i>66</i> , to <i>8/9</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/9</i> , 19 <i>66</i> , and that death occurred at <i>7A</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Earl Beardsley</i>					22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <i>EARL BEARDSLEY</i>		
22d. ADDRESS <i>MARYLAND AVE. Salisbury, Md.</i>					22e. REC'D BY REGISTRAR DATE <i>AUG 11 1966</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>August 11, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parsons Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Salisbury, Maryland</i>		
24. FUNERAL DIRECTOR <i>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</i>					25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>				

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12022

CERTIFICATE OF DEATH

13401

1. PLACE OF DEATH

a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Quantico

c. LENGTH OF STAY IN b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Rt 1, Quantico, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Wicomico

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Quantico

d. STREET ADDRESS

Rt 1, Quantico

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED

(Type or print)

Levin

First

Middle

T.

Gale

Last

4. DATE OF DEATH

August

Day

26

Year

1966

5. SEX

Male

6. COLOR OR RACE

C

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

8/1/1875

9. AGE (In years last birthday)

88 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Merchant

10b. KIND OF BUSINESS OR INDUSTRY

Store

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Mary Gale

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Hopson Gale, Quantico, Maryland

18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Degenerative Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

6 mo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 1920d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1966 to 26 Aug 1966 that (I) (we) last saw the deceased alive on 1966, and that death occurred at 1966 from the causes and on the date stated above.

22a. SIGNATURE

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS.

22c. PHYSICIAN'S NAME (Type)

F. A. Farnell

22d. ADDRESS

Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

9/3/66

23c. NAME OF CEMETERY OR CREMATORY

Quantico cemetery

23d. LOCATION (City, town or county)

Quantico, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

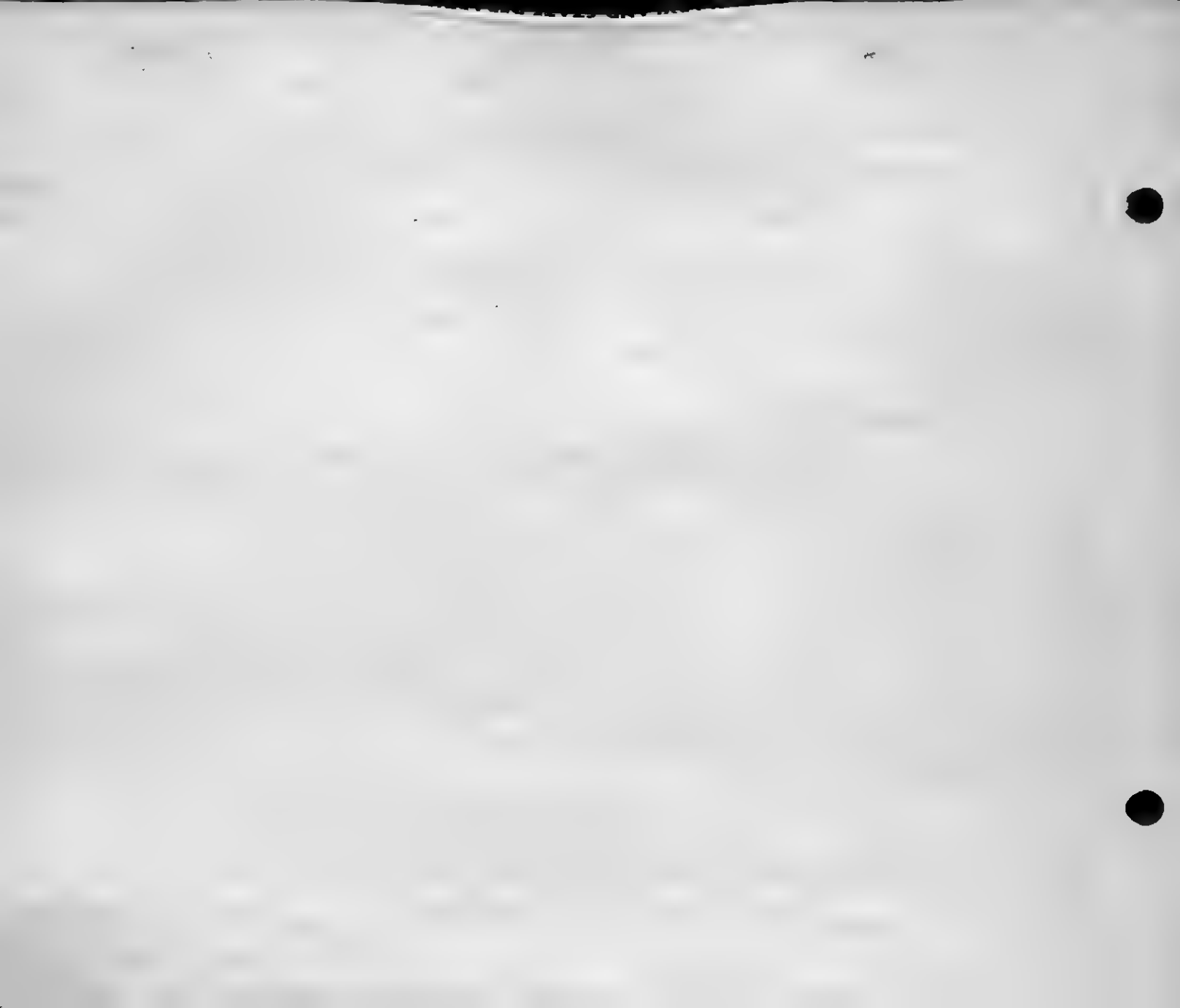
25b. REGISTRAR'S SIGNATURE

SEP 13 1966

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
12023		Item 7 2211 4200		12018							
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>				b. COUNTY <i>WICOMICO</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>DELMAR</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>				d. STREET ADDRESS <i>208 CHESTNUT</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Hubert</i> Middle <i>Warren</i> Last <i>German</i>				4. DATE OF DEATH Month <i>August</i> Day <i>27</i> Year <i>1966</i>							
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-7-1892</i>		9. AGE (In years last birthday) <i>73</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>JEWELER</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>JEWELRY</i>				11. BIRTHPLACE (County & State, or foreign country) <i>DELAWARE</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>HARVEY GERMAN</i>				14. MOTHER'S MAIDEN NAME <i>JENNIE BENSON</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>				16. SOCIAL SECURITY NO. <i>220-32-0064</i>		17. INFORMANT <i>ELIZABETH GERMAN</i>		Address <i>DELMAR-MD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebra</i> DUE TO <i>Tumor left kidney</i> (b) <i>Tumor left kidney</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Nephrosclerosis, Anteriorly occluded Heart Valve</i>											
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>8/26</i> , 19 <i>66</i> to <i>8/28</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/28</i> , 19 <i>66</i> and that death occurred at <i>5:20</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Hubert German</i>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>8-30-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PARSONS</i>		23d. LOCATION (City, town or county) (State) <i>SALISBURY-MD</i>					
24. FUNERAL DIRECTOR <i>Charles W. Marul - Delmar, Del.</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>				25b. REGISTRAR'S SIGNATURE			
				DATE <i>AUG 30 1966</i>							

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (R)
6M 1/66

1
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12024

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12019

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE Maryland b. COUNTY Worcester ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		d. STREET ADDRESS 19 St. Louis Ave.	
3 NAME OF DECEASED (Type or print) First TINNA Middle B. Last HADDER		4 DATE OF DEATH Month 8 Day 18 Year 1966	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-19-1882
9 AGE (in years) last birthday 83 yrs		10 IF UNDER 1 YEAR Months 8 Days 8 Hours 8 Mins 8	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) BERLIN MD		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME ASHER FISHER		14 MOTHER'S MAIDEN NAME LAURA GRAY	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. No	
17 INFORMANT MRS. EDNA JARVIS		Address OCEAN CITY MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia DUE TO 7040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Aspiration of Vomitus DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fractured neck of left femur.			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell at home.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7-3-66 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Own home		20f. (City or town) (County) (State) Ocean City, Worcester, Md.	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , <u>Accident</u> <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED August 22, 1966	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		Address (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.	
23a BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL	23b DATE THEREOF 8/22/66	23c NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK	23d LOCATION (City or Town) (County) (State) BERLIN WIDE MD.
24. FUNERAL DIRECTOR Burbage Funeral Home, Berlin, Md.		25a REC'D BY REGISTRAR DATE AUG 24 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

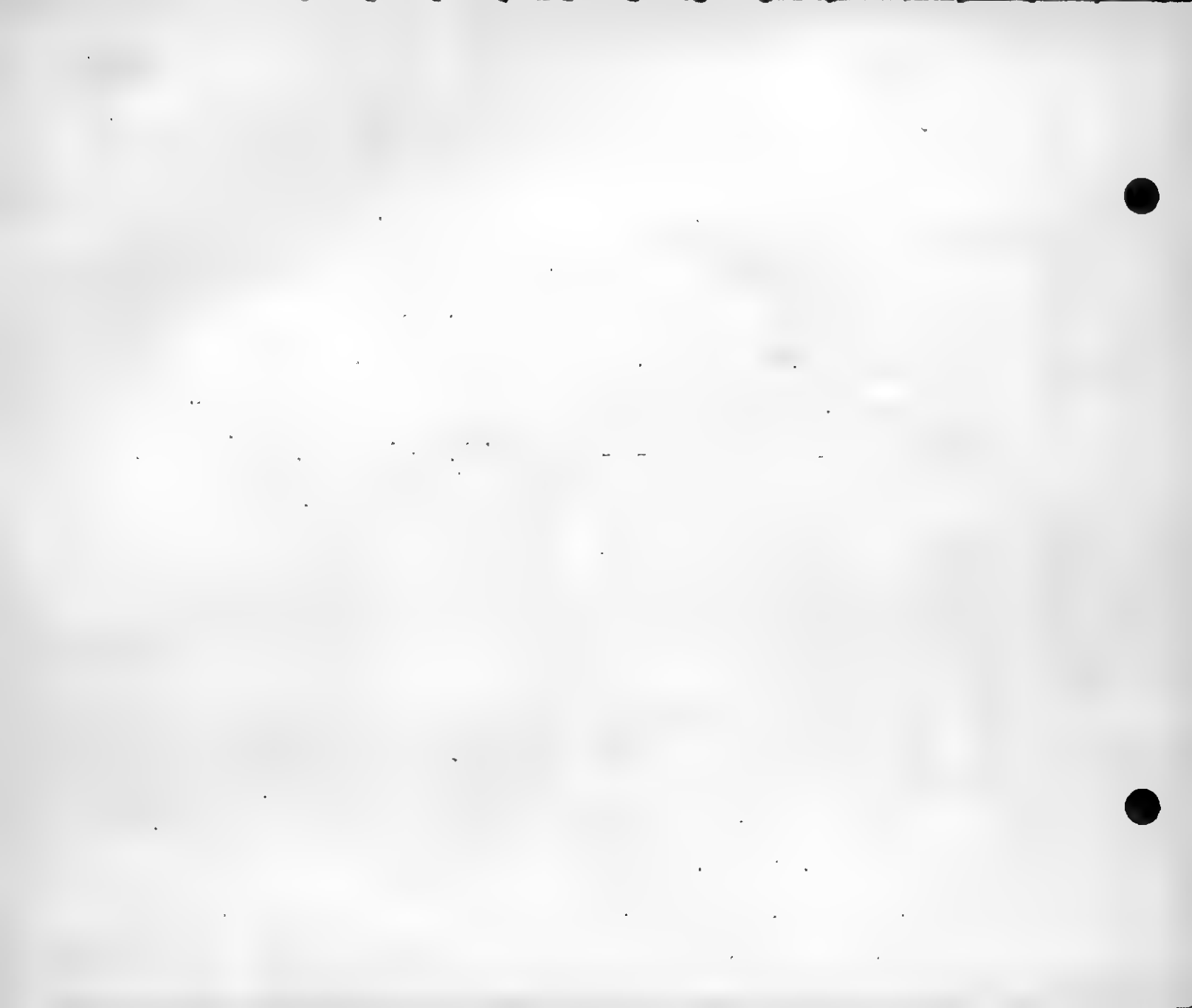
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12025

CERTIFICATE OF DEATH

12022

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 104 W. Isabella Street			e. STREET ADDRESS 104 W. Isabella Street		
3. NAME OF DECEASED (Type or print) First AGNES Middle MARIE Last HENTSCHEL			4. DATE OF DEATH Month August Day 24 Year 19 66		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1890	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 11 Days 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Paul Hentschel			14. MOTHER'S MAIDEN NAME (unk.)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-09-5885	17. INFORMANT Mr. Clay L. Hentschel (Son) 104 W. Isabella St., Salisbury, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) Coronary Artery Sclerosis DUE TO (c) Diabetes Mellitus. Osteoarthritis					INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Oct , 19 66 , to Aug 24 , 19 66 , that (I) (we) last saw the deceased alive on Aug 22 , 19 66 , and that death occurred at 9 A. -M, from the causes and on the date stated above.					
22a. SIGNATURE David J. Gilmore			22b. DATE SIGNED Aug. 25, 1966		
22c. PHYSICIAN'S NAME (Type) Dr. David J. Gilmore			22d. ADDRESS Salisbury, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 27, 1966	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City, town or county) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND			25a. REC'D BY REGISTRAR AUG 29 1966 DATE		
			25b. REGISTRAR'S SIGNATURE Charles Judge		



1
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12025 CERTIFICATE OF DEATH 12023

1. PLACE OF DEATH a. COUNTY WICOMICO b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DELAWARE b. COUNTY SUSSEX c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MILLSBORO d. STREET ADDRESS MILLSBORO e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARVEL HOPKINS		4. DATE OF DEATH Month Day Year AUGUST 22 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 19, 1895
9. AGE (in years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 5 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED POULTRYMAN		10b. KIND OF BUSINESS OR INDUSTRY DELAWARE	
11. BIRTHPLACE (County & State, or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THEODORE M. HOPKINS		14. MOTHER'S MAIDEN NAME ANNIE L. FOWLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 222-07-1881	
17. INFORMANT JENNIE HOPKINS		Address MILLSBORO, DEL.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 352X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-9-66 to 8-22-66 , that (I) (we) last saw the deceased alive on 8-21-66 , and that death occurred at 9:30 M., from the causes and on the date stated above.			
22a. SIGNATURE James H. Cason		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Medical Center Salisbury		22d. ADDRESS Medical Center Salisbury	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-25-66	
23c. NAME OF CEMETERY OR CREMATORY ST. GEORGES CEMETERY		23d. LOCATION (City, town or county) (State) CLARKSVILLE DELA	
24. FUNERAL DIRECTOR A. Rogers Nelson, Frankford, Delaware		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 26 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR #15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12022
12024
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bishopville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>M.</u> Last <u>Hudson</u>		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Lavenia Vinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-40-5984</u>	
17. INFORMANT <u>Mr. William Hudson, Bishopville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cocciemia</u> DUE TO (b) <u>Carcinomatous</u> DUE TO (c) <u>Carcinoma of ovary</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/19</u> , 19 <u>66</u> , to <u>8/24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/24</u> , 19 <u>66</u> and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William E. Hughes</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. Douglas Melson</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-29-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>A. Douglas Melson</u>		25a. REC'D BY REGISTRAR <u>SEP 6 1966</u>	
ADDRESS <u>Frankford, Dela.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and retain page 3 in 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12028

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12025

1 PLACE OF DEATH a COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Montana</u> b. COUNTY <u>Livingston</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Livingston</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>J.</u> Last <u>Hudson</u>		4 DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-24-41</u>
9 AGE (In years last birthday) <u>25</u> yrs		10 IF UNDER 1 YEAR Months <u>12</u> Days <u>13</u> Hours <u>13</u> Min. <u>00</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Air Force</u>		12 INDUSTRY <u>Air Force</u>	
13 BIRTHPLACE (State or foreign country) <u>Calif.</u>		14 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15 FATHER'S NAME <u>BYRON E. HUDSON</u>		16 MOTHER'S MAIDEN NAME <u>Hennie Christiansen</u>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>516-46-5195</u>		18 SOCIAL SECURITY NO <u>516-46-5195</u>	
19 INFORMANT <u>Air Force</u>		Address <u>Dover, Del.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Fracture skull</u> DUE TO (b) <u>2254</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2254</u> DUE TO (b) <u>2254</u> DUE TO (c) <u>2254</u>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple fractures arms, legs, chest</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>Single car accident.</u>	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Single car accident.</u>		20c TIME OF INJURY Month, Day, Year Hour a.m. <u>12:50 pm</u> <u>8-13</u> <u>1966</u>	
20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Route 13</u>	
20f (City or town) <u>Salisbury</u>		(County) <u>Del.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip A. Insley</u>		M.D.	
EXAMINER'S NAME (Type) <u>Philip A. Insley</u>		22. DATE SIGNED <u>8-13-66</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>8-18-66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Mountain View</u>		23d LOCATION (City or Town) <u>Livingston</u>	
23e (County) <u>Mont.</u>		(State)	
24 FUNERAL DIRECTOR <u>William J. Eschmeyer</u>		ADDRESS <u>Georgetown, W.D.</u>	
25a REC'D BY REG. STRAR <u>SEP 1 1966</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12029

12026

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Tyaskin				c. LENGTH OF STAY IN TB Lifetime			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Tyaskin			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lella Middle Hughes Last Hughes				4. DATE OF DEATH Month 8 Day 1 Year 1966			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/1/87	
9. AGE (in years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 1 Hours 1 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wicomico, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME George Gaines				14. MOTHER'S MAIDEN NAME Lizzie Hughes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No				16. SOCIAL SECURITY NO. -			
17. INFORMANT Mrs Lessie Cross, Salisbury, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis heart disease DUE TO (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hr.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 16 July 1966 to 1 Aug 1966 , that (I) (we) last saw the deceased alive on July 23 1966 , and that death occurred at 9:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert J. Jenkins				22b. DATE SIGNED 5 Aug 66			
22c. PHYSICIAN'S NAME (Type) Robert J. Jenkins				22d. ADDRESS FRUITLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/7/66		23c. NAME OF CEMETERY OR CREMATORY New Town Cemetery		23d. LOCATION (City, town or county) (State) Tyaskin, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. J. Messing				25a. REC'D BY REGISTRAR DATE AUG 9 1966			
ADDRESS Bivalve, Maryland				25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/62

12070

DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12027

1. PLACE OF DEATH
a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela-Sharptown Rd c. LENGTH OF STAY IN 1b MD. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Vienna

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before death)
a. STATE MD. b. COUNTY Dor c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna d. STREET ADDRESS —

3. NAME OF DECEASED (Type or print) Norman Dail Hurley 4. DATE OF DEATH August 13th 19 66

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 12/27/28 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 1 day) (Months Days Hours Min.) 37 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter Du Pont Co. 10b. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (State or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Walter J. Hurley 14. MOTHER'S MAIDEN NAME Alberta Langfitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. — 17. INFORMANT Russell Hurley, Vienna, Md. Address —

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 8:34 DUE TO Contracting dust & asphyxiation (b) — DUE TO — (c) —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car overturned--

20c. TIME OF INJURY Month, Day, Year 8-13-66 20d. INJURY OCCURRED While ☒ Not While ☐ at work ☐ at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mardela-Sharptown Rd. 20f. (City or town) Wic. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Phillip A. Insley Sr. M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) Phillip A. Insley Sr. DATE SIGNED 8/14/66

22a. BURIAL, CREMATION REMOVAL (Specify) Burial 22b. DATE THEREOF 8/15/66 22c. NAME OF CEMETERY OR CREMATORY Dor. Memorial Cambridge Md 22d. LOCATION (City, town, or country) 116E. Main St. Salisbury

23. FUNERAL DIRECTOR Ruth S. Mouloughly, East New Market, Md ADDRESS — 24a. RECD BY REGISTRAR — 24b. REGISTRAR'S SIGNATURE Charles Judge

DATE Aug 16 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR #15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
12031 Items 3,5,14 Film 9500 5/14/66 mb 12029													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Wicomico							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital						d. STREET ADDRESS							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Kelley Middle KELLY Last KELLY						4. DATE OF DEATH Month August Day 31 Year 1966							
5. SEX Male						6. COLOR OR RACE White							
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH Aug. 31, 1966							
9. AGE (In years last birthday) 5 yrs. 24 Min.						10. IF UNDER 1 YEAR Months Days Hours Min.							
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						11b. KIND OF BUSINESS OR INDUSTRY							
11. BIRTHPLACE (County & State, or foreign country) Md.						12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Leonard Earl Kelley						14. MOTHER'S MAIDEN NAME Margie Louise Trader							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. (If yes give war or dates of service)							
17. INFORMANT						Address							
18. CAUSE OF DEATH [Enter only one cause—per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C. Section Delivered In Ab. Place												INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.													
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>													
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)													
20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from 8/31, 1966 , to 8/31, 1966 , that (I) (we) last saw the deceased alive on 8/31, 1966 , and that death occurred at 2:35 M, from the causes and on the date stated above.													
22a. SIGNATURE D.S. Underwood													
22b. DATE SIGNED 8/31/66													
22c. PHYSICIAN'S NAME (Type)													
22d. ADDRESS													
22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial													
23b. DATE THEREOF Aug. 31, 1966													
23c. NAME OF CEMETERY OR CREMATORY Belle Haven													
23d. LOCATION (City, town or county) (State) Belle Haven, Va.													
24. FUNERAL DIRECTOR Myrtle Jones Mapp													
25a. REC'D BY REGISTRAR SEP 7 1966													
25b. REGISTRAR'S SIGNATURE Charles Judge													

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

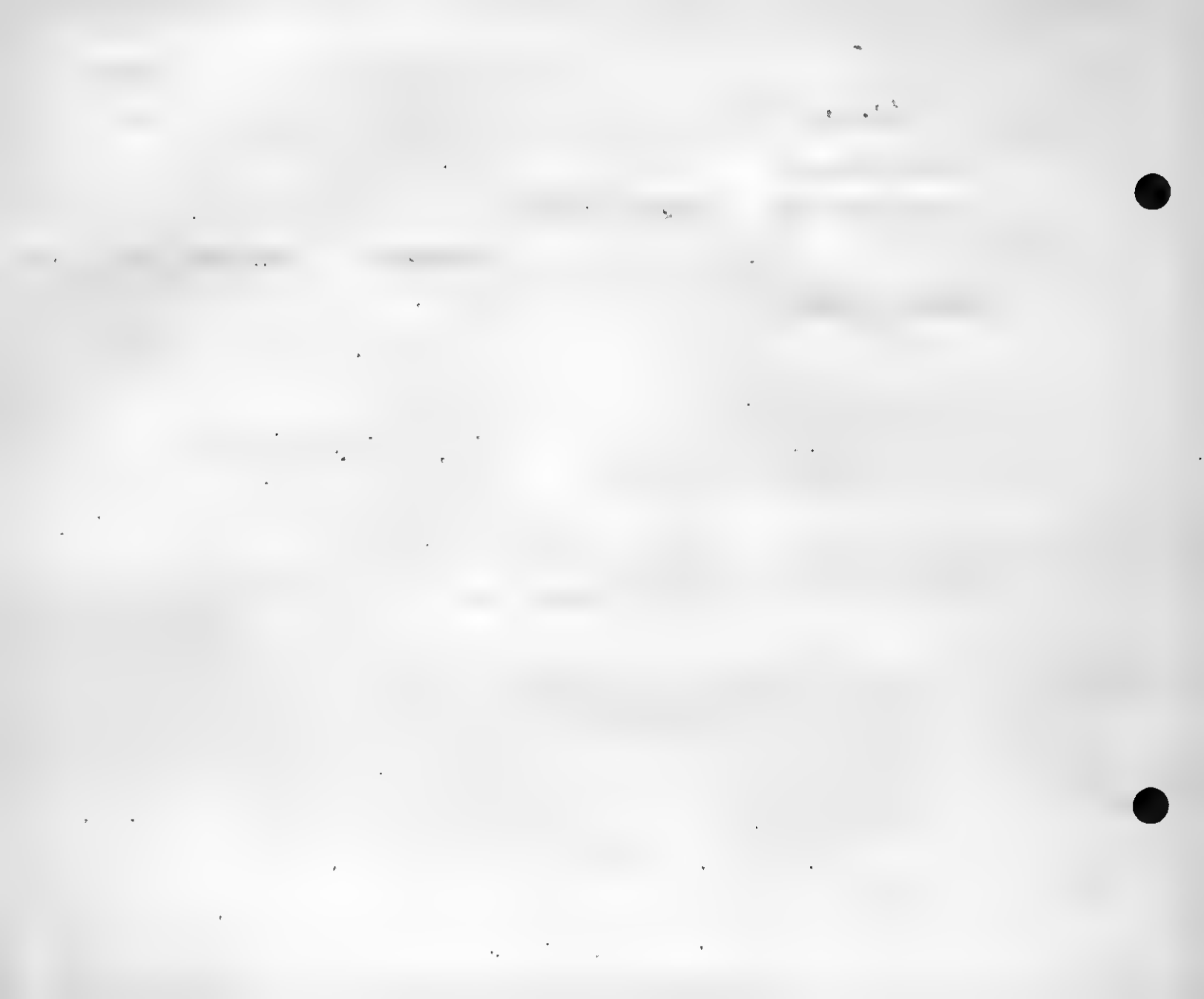
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12032

12028

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>7/23/66</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		d. STREET ADDRESS <i>RD #5, Crooked Oak Lane</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>BERTHA</i> Middle <i>MAE</i> Last <i>Kelley</i>		4. DATE OF DEATH Month <i>August</i> Day <i>23</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 14, 1898</i>
9. AGE (in years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>9</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Wicomico Co., Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Benjamin Thomas Hearn</i>		14. MOTHER'S MAIDEN NAME <i>Alverta Mills</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>--</i>	
17. INFORMANT <i>Mr. Homer D. Kelley (Husband)</i> <i>RD #5, Salisbury, Maryland</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Vagina with</i> DUE TO (b) <i>metastases to lungs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>N/A</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>7/23</i> , 19 <i>66</i> , to <i>8/23</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/23</i> , 19 <i>66</i> , and that death occurred at <i>4:30</i> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>David J. Gilmore</i>		22b. DATE SIGNED <i>Aug. 23, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>Dr. David J. Gilmore</i>		22d. ADDRESS <i>Salisbury, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>August 26/66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Parsons Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Salisbury, Maryland</i>	
24. FUNERAL DIRECTOR <i>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</i>		25a. REC'D BY REGISTRAR <i>AUG 25 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>11th ST</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Palmer Kelly</u>		4. DATE OF DEATH Month Day Year <u>August 21 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 22, 1891</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WASTEGUARD, HOTEL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD KELLY</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN PAYNE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. H. W. KELLY</u>		Address <u>Ocean City MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>THC</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-11</u> , 19 <u>66</u> to <u>8-21</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>8-21</u> , 19 <u>66</u> and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William R. Elliston</u>		22b. DATE SIGNED <u>8-24-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William R. Elliston</u>		22d. ADDRESS <u>M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/24/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>	23d. LOCATION (City, town or county) (State) <u>Berlin Wic. MD</u>
24. FUNERAL DIRECTOR <u>Anna A. Burboye</u>		25a. REC'D BY REGISTRAR <u>AUG 26 1966</u> 25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12034											
12031											
1. PLACE OF DEATH a. COUNTY <u>Nicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Horn town</u> d. STREET ADDRESS <u>Box 39</u>						
3. NAME OF DECEASED (Type or print) <u>FANNIE Wallop Knox</u>					4. DATE OF DEATH <u>August 22 1966</u>						
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 18, 1894</u>		9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward Wallop</u>					14. MOTHER'S MAIDEN NAME <u>Ida Rue</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>William Knox Horn town, Va.</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inter cerebral Hemorrhage</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>5-16</u> , 19 <u>66</u> to <u>5-23</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>5-23</u> , 19 <u>66</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>James C. Gifford</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/24/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Michael Center Salisbury, Md.</u>					22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>8-28-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Tabernacle Bapt. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Horn town, Va.</u>				
24. FUNERAL DIRECTOR <u>Samuel Lloyd New Church, Va.</u> ADDRESS					25a. REC'D BY REGISTRAR <u> </u> DATE <u>AUG 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12035 CERTIFICATE OF DEATH 12032											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY in 1b <u>5 weeks</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>						d. STREET ADDRESS <u>Myrtle Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>RISSIE</u>		Middle <u>J.</u>		Last <u>Landon</u>		4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1966</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 18, 1877</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Obier</u>						14. MOTHER'S MAIDEN NAME <u>Elsie Dameron</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-01-4655</u>		17. INFORMANT <u>Mitchell Landon, Conshohocken, Pa.</u>				Address <u>334 North Lane</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Esophagus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>7/20/1966</u> , 19 <u>66</u> , to <u>8/23/1966</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/23/1966</u> , and that death occurred at <u>2:40</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>O. J. Burton</u>						22d. ADDRESS <u>Salisbury, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 25, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunnyridge Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Crisfield, Md.</u>			
24. FUNERAL DIRECTOR <u>Bradshaw & Sons, Crisfield, Md.</u>						ADDRESS		25a. REC'D BY REGISTRAR <u>AUG 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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(M)
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12036					12033				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <u>Wicomico</u>					a. STATE <u>MARYLAND</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>					b. COUNTY <u>QUANTICO</u>				
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>					d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last <u>Baby</u> <u>LAWRENCE</u>					Month Day Year <u>AUGUST</u> <u>6</u> , <u>1966</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUGUST 5, 1966</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>UNDER 1 YEAR</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>CAROLYN FRANCES LAWRENCE</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT <u>CAROLYN LAWRENCE</u>		
							Address <u>Quantico, Maryland</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity Birth wt 1820 gms.</u> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>8/5</u> , 19 <u>66</u> , to <u>8/6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/6</u> , 19 <u>66</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Alfred C Kolls</u>					M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>8/6/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>ALFRED C KOLLS</u>					22d. ADDRESS <u>Medical Center Salisbury, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>8/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Quantico</u>		23d. LOCATION (City, town or county) (State) <u>Quantico, Maryland</u>		
24. FUNERAL DIRECTOR <u>Christine Stewart</u>					ADDRESS <u>Salisbury</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		
							25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
							DATE <u>AUG 11 1966</u>		

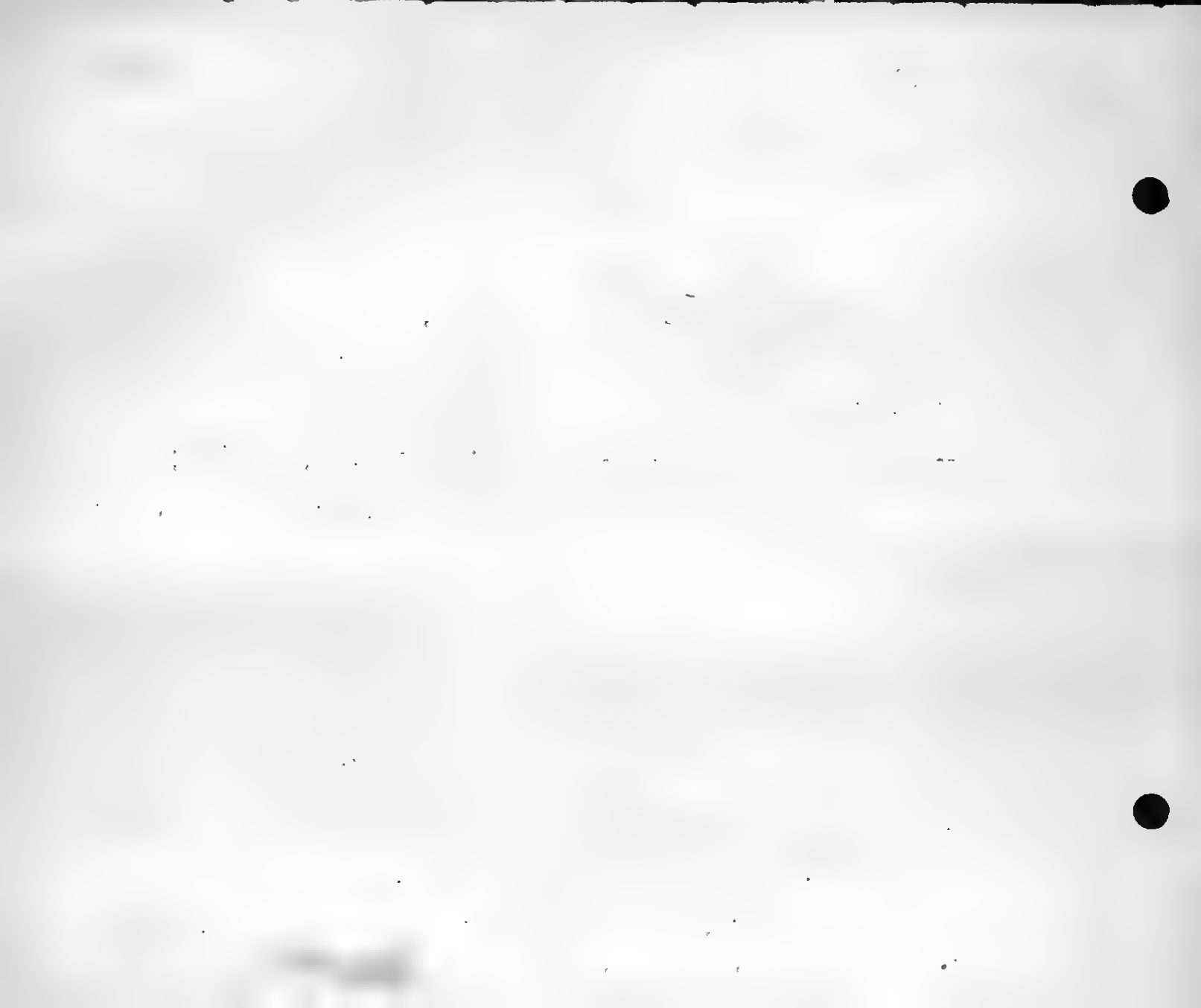
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739

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12037						12034					
1. PLACE OF DEATH a. COUNTY Wicomico						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital						d. STREET ADDRESS 403 Truitt Street					
3. NAME OF DECEASED (Type or print) First Middle Last Nora Ellen Layfield			4. DATE OF DEATH Month Day Year August 11 1966								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15, 1884		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 2 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Laurel, Delaware			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas Hastings						14. MOTHER'S MAIDEN NAME Fannie Records					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) --				16. SOCIAL SECURITY NO. 302-875-3467		17. INFORMANT Address Mrs. Pauline Hastings Massey, 403 Truitt Street, Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) NA							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 10, 1966</u> , to <u>Aug 11, 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug 11, 1966</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Wilbur Ellis Jr.</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/12/66			
22c. PHYSICIAN'S NAME (Type) Dr. Wilbur Ellis						22d. ADDRESS Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 14, 66		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town or county) (State) Salisbury, Maryland					
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND						25a. REC'D BY REGISTRAR DATE AUG 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



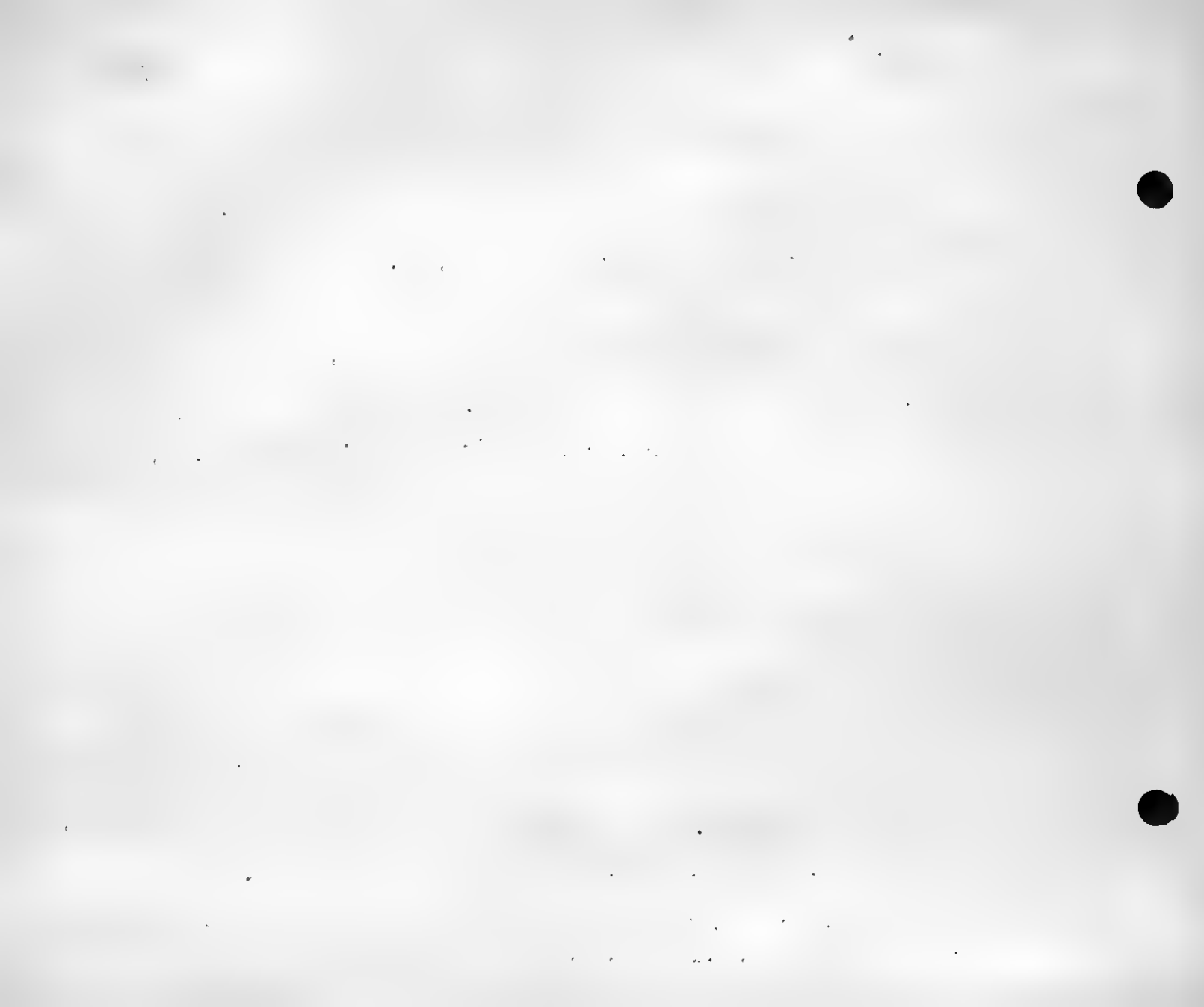
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12038					12035						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Wicomico					a. STATE Maryland						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury					b. COUNTY Wicomico						
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 316 Charles Street					d. STREET ADDRESS 316 Charles Street						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE		
First Middle Last Walter Leroy Llewellyn, Sr.			Month Day Year August 11 1966			Male			White		
7. MARRIED			8. DATE OF BIRTH			9. AGE (In years last birthday)			10. AGE (In years last birthday)		
NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			December 31, 1887			78 yrs.			78 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Retired Mechanist						Phoenixville, Pennsylvania			USA		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
James Llewellyn						Elizabeth --					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT					
No			161-03-0798-A			Mrs. Minnie L. Llewellyn (wife) 316 Charles Street, Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the throat + mandible</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 year</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
			N/A								
20c. TIME OF INJURY			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		
Month, Day, Year Hour a.m. p.m. 19			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>								
21. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> , 19 <u>66</u> , to <u>8/11</u> , 19 <u>66</u> , that (I) was last saw the deceased alive on <u>8/9</u> , 19 <u>66</u> , and that death occurred at <u>6:15</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
<u>George H. Henning</u>						August 12, 1966					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
Dr. George H. Henning						Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)				
Burial			August 15/66		Sunset Memorial Park		Philadelphia, Pennsylvania				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR					
HOLLOWAY & COMPANY, SALISBURY, MARYLAND						25b. REGISTRAR'S SIGNATURE AUG 15 1966 <u>Charles Judge</u>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

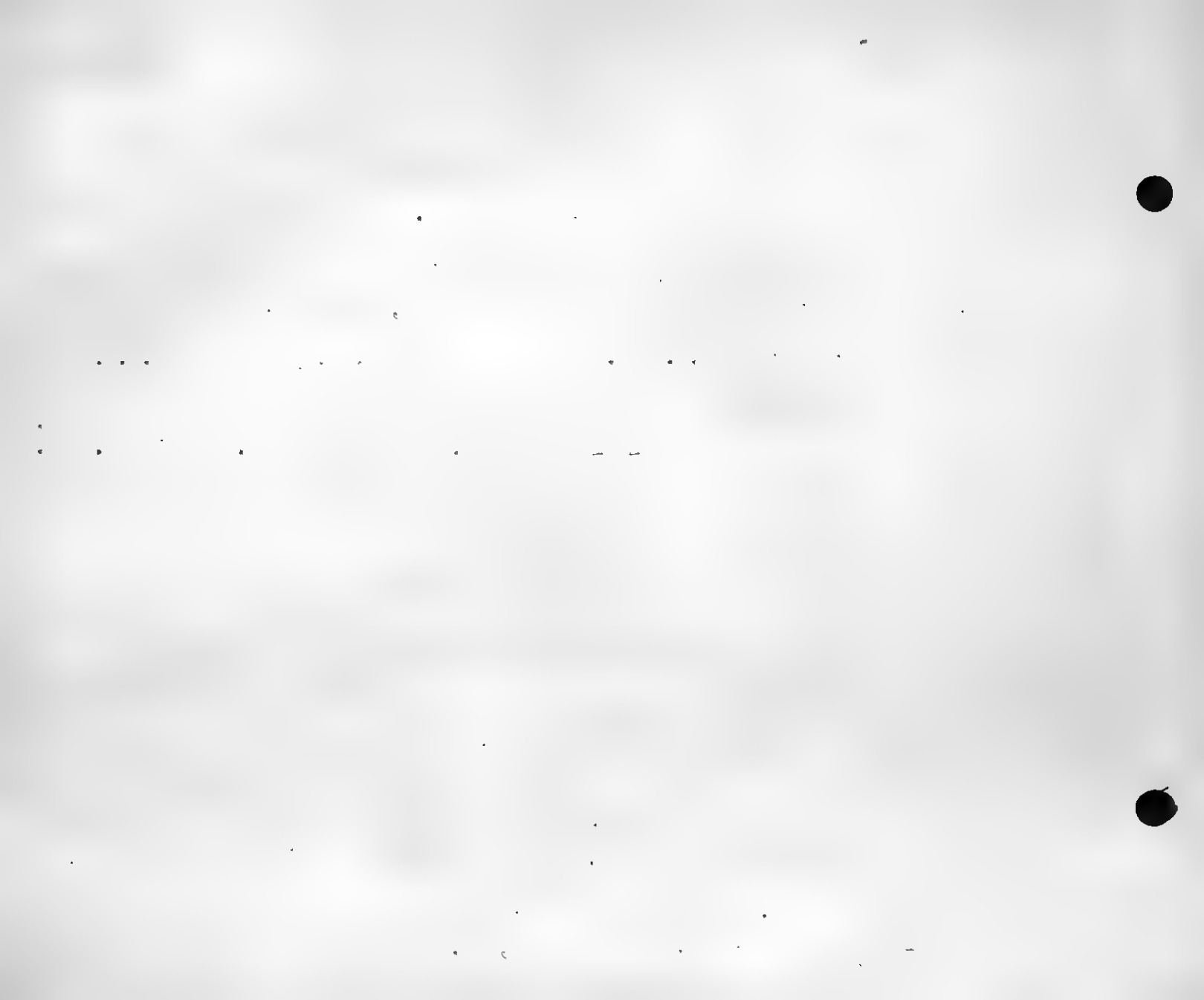
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12039

12036

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>none</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>				d. STREET ADDRESS <u>417 E. Howell Avenue</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALLACE Lunceford</u>				4. DATE OF DEATH Month Day Year <u>August 18, 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 30, 1886</u>	
9. AGE (in years last birthday) <u>80 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Car Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>R.F. & P. RR</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Delaplane, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Henry Lunceford</u>				14. MOTHER'S MAIDEN NAME <u>Mary Levinia Lawrence</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>718-14-2993</u>		17. INFORMANT Address <u>Mary W. Lunceford, 417 E. Howell Ave., Va. Alex.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> (c) <u>Coronary arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>± 10 hrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Salisbury Md</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>8-16, 1966</u> to <u>8-18, 1966</u> , that (I) (we) last saw the deceased alive on <u>8-18, 1966</u> , and that death occurred at <u>6:45</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>James R. Clifford</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. CLIFFORD</u>				22d. ADDRESS <u>Medical Center Salisbury Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>Aug. 22, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Alexandria Virginia</u>	
24. FUNERAL DIRECTOR <u>Everly Wheatley Funeral Home</u>				ADDRESS <u>Alexandria, Va.</u>		25a. REC'D BY REGISTRAR <u>AUG 22 1966</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
12040					12037					
Item 7 Film 8319 8/12/66										
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>New Church</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>New Church, Va.</u>					
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>A.</u> Last <u>MARINER</u>					4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/14/1887</u>		9. AGE (in years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Accomack, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Watson</u>					14. MOTHER'S MAIDEN NAME <u>Mary E. Thornton</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>225-40-49958</u>		17. INFORMANT <u>C. Lee Davis</u>		Address <u>New Church, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Emboli</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>										
INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 yr.</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/1</u> , 19 <u>66</u> , to <u>8/5</u> , 19 <u>66</u> , that (I) <u>no</u> last saw the deceased alive on <u>8/5</u> , 19 <u>66</u> , and that death occurred at <u>11:20</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>George H. Henning</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>George H. Henning</u>					22d. ADDRESS <u>Peninsula General Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)				
<u>Burial</u>		<u>8/7/66</u>		<u>Nelsons Ceme.</u>		<u>New Church, Virginia</u>				
24. FUNERAL DIRECTOR <u>For Funeral Home Temperanceville, Va.</u>					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
							DATE <u>AUG 10 1966</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12041

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12038

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Delaware b COUNTY Sussex	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Salisbury		c LENGTH OF STAY IN TB Frankford	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hosp.		d STREET ADDRESS Frankford	
3. NAME OF DECEASED (Type or print) FRANCES MASON		4 DATE OF DEATH Month 8 Day 7 Year 1966	
5. SEX Female	6. CD. OR OR RACE Col.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-10-1919
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) 47 yrs
11 BIRTHPLACE (State or foreign country) South Carolina		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Fred Daniels		14. MOTHER'S MAIDEN NAME Sadie Mills	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. -	
17 INFORMANT Mrs. Sadie Mills, Frankford, Del.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 5.271 DUE TO (b) Exaggerated diffuse both lungs DUE TO (c) Exaggerated Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Exaggerated			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Phyllis A. Insley M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Phyllis A. Insley		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED 8-12-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-13-66	23c. NAME OF CEMETERY OR CREMATORY Antioch Cemetery	23d. LOCATION (City or Town) (County) (State) Frankford, Sussex, Del.
24. FUNERAL DIRECTOR Charles Judge		ADDRESS Frankford, Delaware	
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE AUG 15 1966			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (Rev. 6-1-66)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12042

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12039

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if not in on Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b Mardela Springs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital				e. STREET ADDRESS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First GEORGE Middle W. Last MASSEY				4 DATE OF DEATH Month August Day 4 Year 19 66			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 1-31-07	
9 AGE (In years last birthday) 59 yrs		10 UNDER 1 YEAR Months 59 Days 59 Hours 59 Min 59		11 BIRTHPLACE (State or foreign country) Delaware		12 CITIZEN OF WHAT COUNTRY? USA	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming				10b KIND OF BUSINESS OR INDUSTRY			
13 FATHER'S NAME Edwin T. Massey				14 MOTHER'S MAIDEN NAME Bertha A. Morris			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16 SOCIAL SECURITY NO 219-14-3546		17 INFORMANT Address Mrs. Martha Massey, Mardela, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease DUE TO (c) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH Minutes Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) 109 Camden Ave., Salisbury, Md.				22. DATE SIGNED August 5, 1966			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF 8/7/1966		23c NAME OF CEMETERY OR CREMATORY Riverton		23d LOCATION (City or Town) (County) (State) Mardela, Wicomico, Md.	
24 FUNERAL DIRECTOR ADDRESS Newman Funeral Home, Easton, Md.				25a REC'D BY REGISTRAR DATE AUG 10 1966		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (May, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

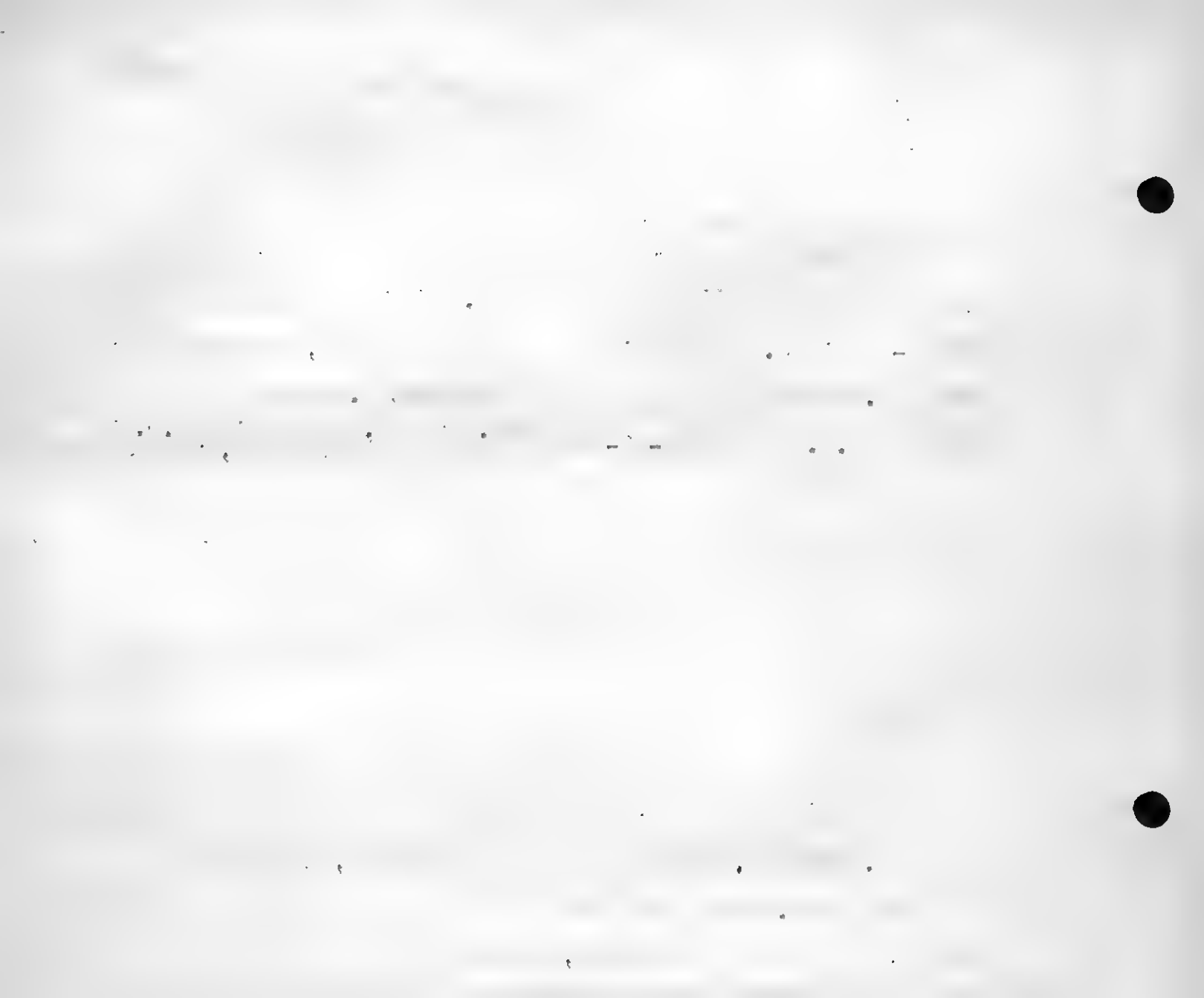
VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
12043									
12040									
1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY			c. LENGTH OF STAY IN 1b 16 DAYS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pocomoke City				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL HOSPITAL					d. STREET ADDRESS 209 MARKET STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BLANCHE PAULINE MILES					4. DATE OF DEATH Month Day Year AUGUST 7 1966				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 5, 1890		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES CLERK			10b. KIND OF BUSINESS OR INDUSTRY RETAIL CLOTHING		11. BIRTHPLACE (County & State, or foreign country) WORCESTER COUNTY, MARYLAND			12. COUNTRY OF WHAT CITIZEN? U. S. A.	
13. FATHER'S NAME ALEC G. JUSTICE					14. MOTHER'S MAIDEN NAME MARY FOSTER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 220-09-1135-A		17. INFORMANT Address WILLIAM A. MILES, Pocomoke City, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>menia</u> 6000 DUE TO (b) <u>chronic pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>unknown</u>								INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7-22, 1966 to 8-7, 1966, that (I) (we) last saw the deceased alive on 8-7, 1966 and that death occurred at 8:45 A.M. from the causes and on the date stated above.									
22a. SIGNATURE W. R. ELLIS, JR.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-7-66		
22c. PHYSICIAN'S NAME (Type) W. R. ELLIS, JR., M.D.					22d. ADDRESS SALISBURY, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 8-9-1966		23c. NAME OF CEMETERY OR CREMATORY ST. MARY EPISCOPAL			23d. LOCATION (City, town or county) (State) Pocomoke City, MARYLAND	
24. FUNERAL DIRECTOR Robert H. Watson					25a. REC'D BY REGISTRAR Pocomoke City, MD.		25b. REGISTRAR'S SIGNATURE J. M. Jones		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>						d. STREET ADDRESS <u>Route #1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last (DINK) <u>Jesse HARVEY MILLER</u>						4. DATE OF DEATH Month Day Year <u>AUGUST 5 1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 25/1914</u>		9. AGE (in years last birthday) <u>52 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>6 10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner - Taxi Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Taxi</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bowling Green, Florida</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Samuel C. Miller</u>						14. MOTHER'S MAIDEN NAME <u>Margaret M. Altman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>W.W.#II</u>				16. SOCIAL SECURITY NO. <u>220-03-4911</u>		17. INFORMANT Address <u>Mrs. Betty R. Miller (Wife) R.D.#1 (St. Luke Rd) Salisbury, Maryland 21801</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Antero-septal myocardial infarction</u> (c) <u></u> DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>66</u> to <u>Aug 5</u> , 19 <u>66</u> , that (I)-(we) last saw the deceased alive on <u>Aug 5</u> , 19 <u>66</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>Robert T. Adkins</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert T. Adkins</u> 22b. DATE SIGNED <u>5 Aug 66</u> MED. DIRECTOR <input checked="" type="checkbox"/> ATENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> ATENDING PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Fruitland, Maryland</u>										INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u> <u>17 days.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Aug. 9/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>				23d. LOCATION (City, town or county) (State) <u>Salisbury Maryland</u>	
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY SALISBURY, MARYLAND</u>						25a. REC'D BY REGISTRAR <u>AUG 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #1270 7/11/66 pc

12045

CERTIFICATE OF DEATH

12042

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		d. STREET ADDRESS Crisfield Lane	
3 NAME OF DECEASED (Type or print) First Middle Last Thomas David Nicholls		4 DATE OF DEATH Month Day Year 8 15 19 66	
5 SEX Male		6 COLOR OR RACE White	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH JAN. 20, 1920	
9 AGE (In years last birthday) 55 yrs.		10a. USUA. OCC. PATION (Give kind of work done during most of working life, even if retired) POULTRY	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) SCRANTON, PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOMAS D. NICHOLLS	
14. MOTHER'S MAIDEN NAME SARAH ANNE HUGHES		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS NAOMIE B. NICHOLLS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Broncho Pneumonia 178 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Seminoma with Tuberculosis DUE TO (c) and Spinal Metastases		INTERVAL BETWEEN ONSET AND DEATH 5-7 days 9-11 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/3, 1966 to 8/15, 1966 , that (I) (we) last saw the deceased alive on 8/15, 1966 , and that death occurred at 6:10 P.M. from causes and on the date stated above			
22a. SIGNATURE C. H. Winnacott		22b. DATE SIGNED 8/16/66	
22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, or other disposition BURIAL		23b. DATE THEREOF 8-18-1966	
23c. NAME OF CEMETERY OR CREMATORY OLIVER T. BEECHWOOD CEM.		23d. LOCATION (City or Town) (County) (State) PRINCESS ANNE, MD.	
24. FUNERAL DIRECTOR LEVIN R. WILSON		25. REG'D BY REGISTRAR Aug 19 1966	
26. REGISTRAR'S SIGNATURE Charles Judge		27. REGISTRAR'S NAME Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

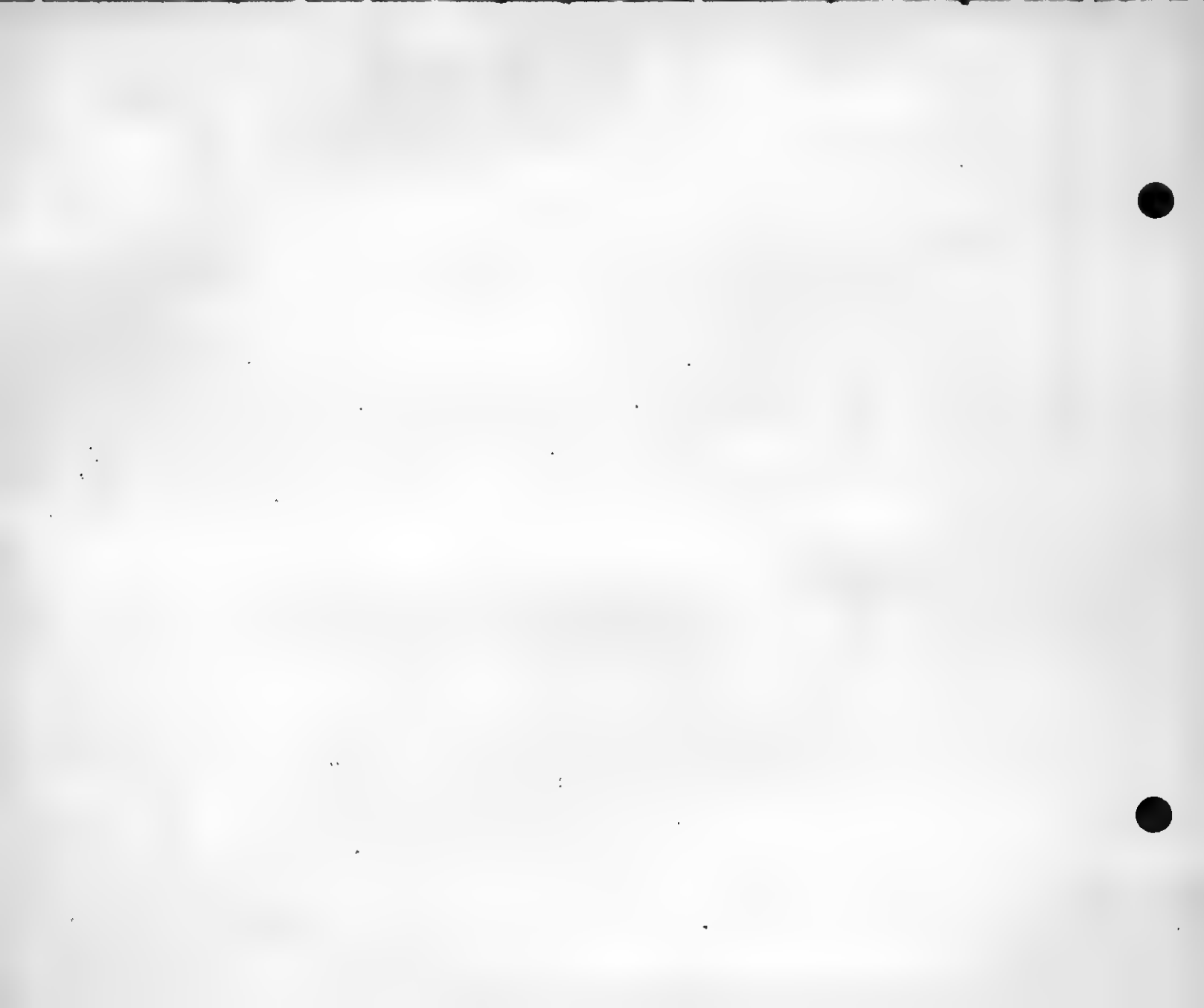
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12046 CERTIFICATE OF DEATH 12043											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 88 yrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Delmar					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 420 E.State St,						d. STREET ADDRESS 420 E.State				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ENOLA Middle MAE Last PHILLIPS						4. DATE OF DEATH Month Aug. Day 9, Year 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 26, 1877		9. AGE (in years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Delmar, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Burton LeCates						14. MOTHER'S MAIDEN NAME Letitia Hearn					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -----		17. INFORMANT Lillian Bryant, Delmar, Md.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Heart Disease OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) terminal gastrointestinal hemorrhage of unknown etiology										INTERVAL BETWEEN ONSET AND DEATH 6 mos 5 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 60 to death , 19 66 , that (I) (we) last saw the deceased alive on Aug 8 19 66 , and that death occurred at 6:10 PM , from the causes and on the date stated above.											
22a. SIGNATURE Ernest Larmore						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-10-66			
22c. PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore						22d. ADDRESS Delmar, Del.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8-12-66		23c. NAME OF CEMETERY OR CREMATORY St. Stephens		23d. LOCATION (City, town or county) (State) Delmar, Del.			
24. FUNERAL DIRECTOR Charles W. Marvel, Delmar, Del.						25a. REC'D BY REGISTRAR DATE AUG 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ocean City						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS R. F. D			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hermine LILLIAN Price			4. DATE OF DEATH Month Day Year August 8 1966								
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB 4, 1909		9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) BAMBERG S.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CLARENCE MC MILLAN					14. MOTHER'S MAIDEN NAME CARRIE SMITH						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. NO		17. INFORMANT MR. JAMES PRICE, Ocean City MD						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. OATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 1 day			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 8-7, 1966 to 8-8, 1966 that (I) (we) last saw the deceased alive on 8-8, 1966 and that death occurred at 7:30 AM, from the causes and on the date stated above.											
22a. SIGNATURE William R. Ellis, Jr.					ATTENDING PHYS. <input checked="" type="checkbox"/> M.O. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 8-8-66			
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8/11/66		23c. NAME OF CEMETERY OR CREMATORY ST. PAULS EVERGREEN		23d. LOCATION (City, town or county) (State) BETHUN MD					
24. FUNERAL DIRECTOR Anna A. Burdage					25a. REC'D BY REGISTRAR AUG 12 1966					25b. REGISTRAR'S SIGNATURE Charles Judge	



12048

CERTIFICATE OF DEATH

12045

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital		e. STREET ADDRESS 120 N. Somerset Avenue	
3. NAME OF DECEASED (Type or print) First Ralph Middle - Last Riggin		4. DATE OF DEATH Month August Day 21 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1877
9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 21 Days 19 Hours 66 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seafood Dealer		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Riggin		14. MOTHER'S MAIDEN NAME Mary Riggin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-34-3307	
17. INFORMANT Records of Pine Bluff State Hospital, Salisbury, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) senile degeneration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 5 , 19 66 , to Aug. 21 19 66 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Aug. 21 19 66 , and that death occurred at 11 p.m., from causes and on the date stated above.			
22a. SIGNATURE E. P. Ritchings		22b. DATE SIGNED Aug. 22, 1966	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.		22d. ADDRESS Pine Bluff State Hospital Salisbury, Maryland-21801	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/24/1966	23c. NAME OF CEMETERY OR CREMATORY Sunnyridge	23d. LOCATION (City or Town) (County) (State) Hopewell Somerset, Md.
24. FUNERAL DIRECTOR James Herman		25a. REC'D BY REGISTRAR DATE AUG 26 1966	
ADDRESS Crisfield, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12049

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12046

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>N.Y.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jonawanda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL Hospital</u>		e. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <u>Joseph J. Sackey Jr.</u>		4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1966</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-16-46</u>
9 AGE (In years last birthday) <u>19</u> yrs		IF UNDER 1 YEAR F UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Air Force</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Air Force</u>	
11 BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph J. Sackey Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Whipple</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>		16. U.S. A. SECURITY NO <u>111-38-6928</u>	
17 INFORMANT <u>Air Force</u>		Address <u>Dover, Del.</u>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> + DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Crushed chest</u> (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Crushed chest</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>one car accident</u>	
20c. TIME OF INJURY Month Day Year <u>12:50 pm 8-13 1966</u>		20d. INJURY OCCURRED Where <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Route 13</u>		20f. (City or town) (County) (State) <u>Salisbury W.D.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles J. Insley</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Ph. V. P. A. Insley</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town or county)	
22. DATE SIGNED <u>8-13-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-18-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	23d. LOCATION (City or town) (County) (State) <u>Jonawanda N.Y.</u>
24. FUNERAL DIRECTOR <u>William J. Eckman Jr.</u>		ADDRESS <u>Georgetown, W.D.</u>	
25a. REC'D BY REGISTRAR <u>DATE AUG 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u>	

12050

CERTIFICATE OF DEATH

12047

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 33 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS 115 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruth Middle Amelia Last Schmick		4. DATE OF DEATH Month Aug. Day 13 Year 19 66	
SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1895
9. AGE (in years last birthday) yrs 71		IF UNDER 1 YEAR Months 13 Days 19 Hours 66 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State or foreign country) Accident, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gustav Goehringer		14. MOTHER'S MAIDEN NAME Anna Giessmann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 218-10-8993	
17. INFORMANT Lawrence Schmick, Preston, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO (b) Hypertensive arteriosclerotic cardiovascular DUE TO disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 9 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Old fracture, right hip - surgical reduction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 7/11, 1966 , to Aug. 13, 1966 , that (we) last saw the deceased alive on Aug. 13, 1966 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Charles H. Winnacott, M.D.		22b. DATE SIGNED 8/13/66	
22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott, M.D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 16, 1966	23c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery	23d. LOCATION (City or Town) (County) (State) Preston, Maryland
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR Aug 18 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

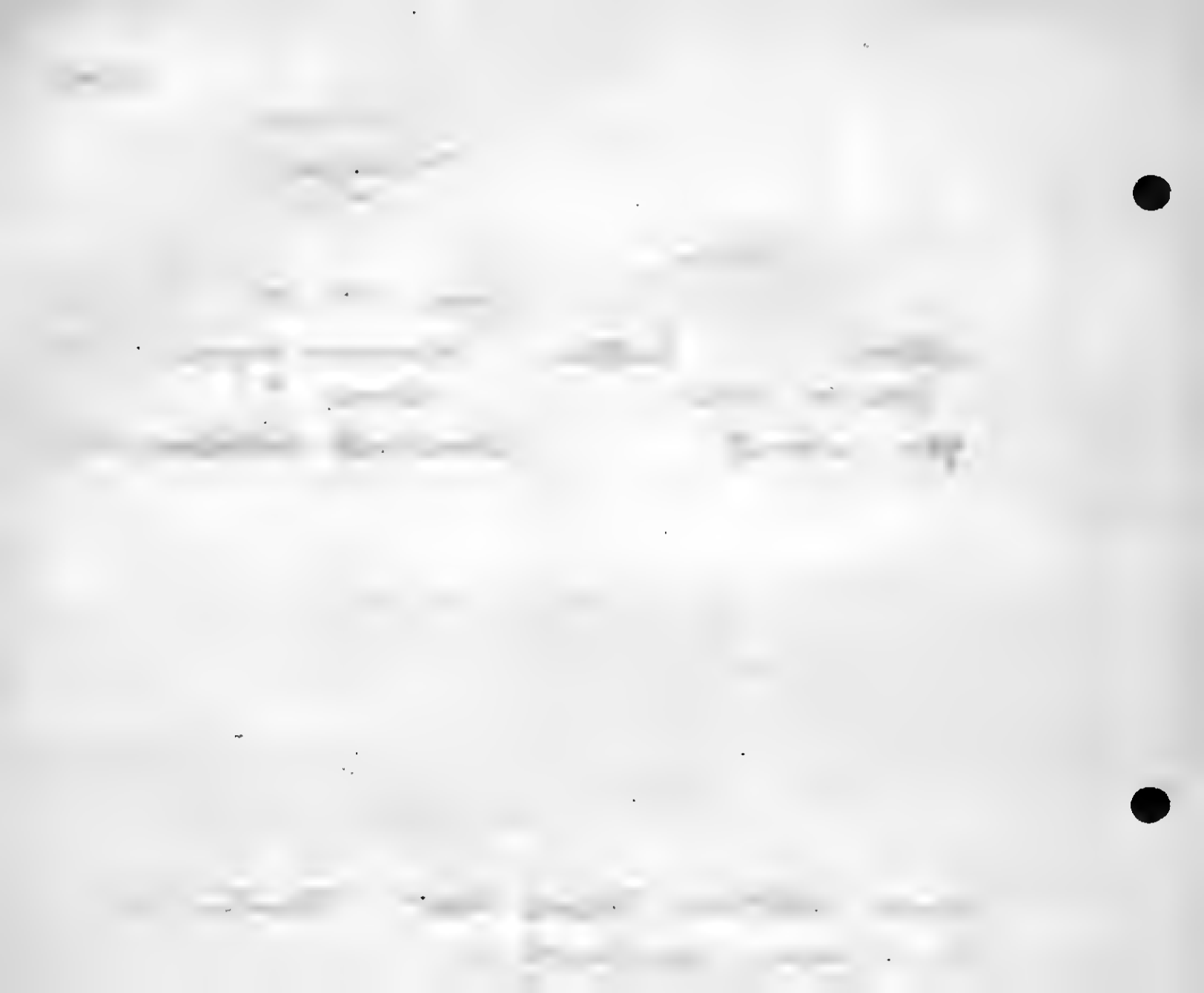
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12051 CERTIFICATE OF DEATH 12048											
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tylerton</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>					d. STREET ADDRESS <u>Rural</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>L.</u> Last <u>SMITH</u>			4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1966</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1887</u>		9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Crisfield, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Landon</u>					14. MOTHER'S MAIDEN NAME <u>Julia Charnick</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Jerome Smith, Same as 2. abcd</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 7x11 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u>Coronary Disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I (this hospital) attended the deceased from <u>8-8-66</u> , 19 <u>66</u> to <u>8-20-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-20-66</u> , 19 <u>66</u> , and that death occurred at <u>30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Nevin W. Todd, Jr.</u>					22b. DATE SIGNED <u>Aug 23 1966</u>			22c. PHYSICIAN'S NAME (Type) <u>Nevin W. Todd, Jr.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>Aug. 23, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Tylerton Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Tylerton, Md.</u>		
24. FUNERAL DIRECTOR <u>Bradshaw & Sons, Crisfield, Md.</u>					25a. REC'D BY REGISTRAR <u>AUG 25 1966</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12052
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Delaware</i> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Millsboro</i> d. STREET ADDRESS <i>2nd St.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Smith</i> Last <i>Smith</i>		4. DATE OF DEATH Month <i>August</i> Day <i>27</i> Year <i>1966</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 14 1918</i> 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>factory</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>factory</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Accomack Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John H. Smith</i>		14. MOTHER'S MAIDEN NAME <i>Bessie</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes give war or dates of service) <i>war II</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Archie Smith - Millsboro, Del.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> Gonitions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary atherosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Severe hypertension vascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs.</i> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. AGGIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>8-25</i> , 1966, to <i>8-27</i> , 1966, that (I) (we) last saw the deceased alive on <i>8-26</i> , 1966, and that death occurred at <i>8 A.M.</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert R. White, Jr.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<i>Burial</i>	<i>Sept. 4, 1966</i>	<i>Shiloh Baptist</i>	<i>Farmington, Va.</i>
24. FUNERAL DIRECTOR <i>Samuel Sauer</i>		25a. REG'D BY REGISTRAR <i>SEP 1 1966</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12053

Items #8 & 9

CERTIFICATE OF DEATH

12050

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>SUSSEX</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Viola</u> d. STREET ADDRESS <u>Box H</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lemuel</u> <u>Spence</u>		4. DATE OF DEATH Month Day Year <u>August</u> <u>6</u> <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1898</u>
9. AGE (in years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>67</u> <u>0</u> <u>0</u> <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Spence</u>		14. MOTHER'S MAIDEN NAME <u>Emma Scott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>1919</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Mrs. Dorothy Spence, Viola, Delaware</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Larynx</u> <u>161X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>66</u> , to <u>Aug 6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug 6</u> , 19 <u>66</u> , and that death occurred at <u>2:57</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>Aug 7, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Hubrey C. Smoot</u>		22d. ADDRESS <u>Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 10, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery, Camden, Delaware</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>William Berry Jr., Milford, Del.</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>AUG 15 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Nicomico</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>S. C.</u> b. COUNTY <u>Mount Pleasant</u>		3. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL Hospital</u>						d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) First <u>Nathan</u> Middle <u>Swinton</u> Last <u>Swinton</u>			4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1966</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/6/1904</u>		9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Unknown</u>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jacob Swinton</u>					14. MOTHER'S MAIDEN NAME <u>Rosa Smith</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT <u>P.S. Johnson Funeral Home S. Carolina</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinomatous</u> 151X DUE TO (b) <u>Ca of head of Pancreas.</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8-19</u> , 19 <u>66</u> , to <u>8-20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-20</u> 19 <u>66</u> , and that death occurred at <u>9 P.</u> M. from the causes and on the date stated above.										
22a. SIGNATURE <u>Joseph C. Fitzgerald, M.D.</u>						22b. DATE SIGNED <u>8/24/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH C. FITZGERALD</u>						22d. ADDRESS <u>Medical Center, Salisbury, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>8/24</u>		23c. NAME OF CEMETERY OR CREMATORY <u>mt. Pleasant Cem</u>			23d. LOCATION (City, town or county) (State) <u>mt. Pleasant S.C.</u>		
24. FUNERAL DIRECTOR <u>Booker West Funeral Home</u>						25a. REC'D BY REGISTRAR <u>SEP 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12055 CERTIFICATE OF DEATH 12052

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>408 Linden Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Lubertha</u>		4. DATE OF DEATH <u>August 20 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1894</u>
9. AGE (In years, last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levi H. James</u>		14. MOTHER'S MAIDEN NAME <u>Cordelia Kitchen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-14-6455</u>	
17. INFORMANT <u>Lenora James</u>		Address <u>Pocomoke City, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>wound abscess.</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic carcinoma of rectum.</u>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic cardiovascular disease.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year <u>None</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 10, 1966</u> , to <u>Aug 20, 1966</u> , that (I) (we) last saw the deceased alive on <u>8/20 1966</u> , and that death occurred at <u>6:00</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Fred R. Eilber</u>		22b. DATE SIGNED <u>8/20/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRED R. EILBER</u>		22d. ADDRESS <u>Peninsula General Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-23-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hall's Hill Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Pocomoke City, Md.</u>	
24. FUNERAL DIRECTOR <u>Samuel S. ...</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 24 1966</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1072

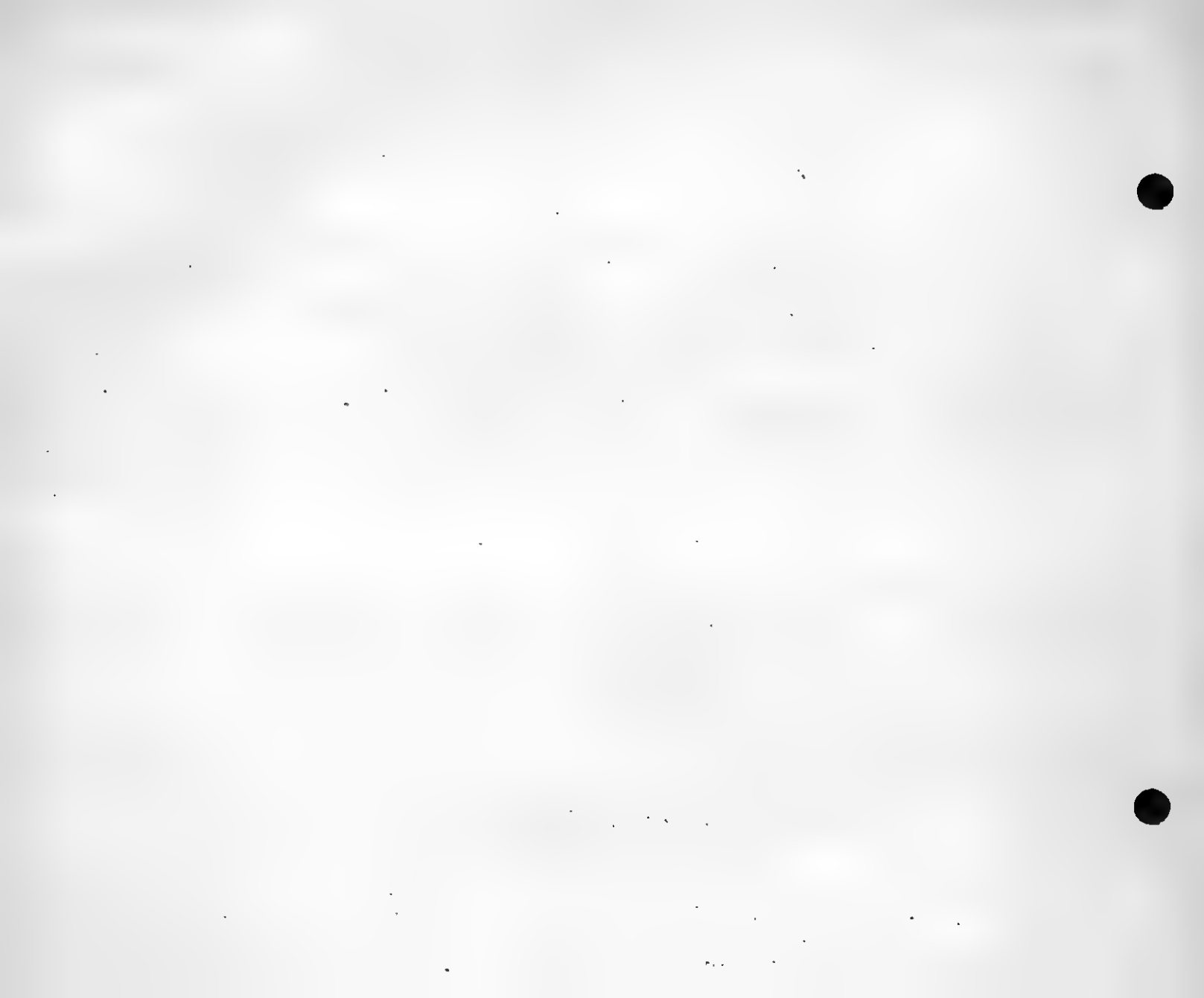
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12053

12053

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY in 1b 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL HOSPITAL		d. STREET ADDRESS NANTICKE (RURAL)	
3. NAME OF DECEASED (Type or print) First HARRY Middle HARDSTY Last THOMAS		4. DATE OF DEATH Month AUGUST Day 9 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 2, 1889
9. AGE (in years last birthday) 76 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE KEEPER		10b. KIND OF BUSINESS OR INDUSTRY MERCHANT	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME GEORGE THOMAS		14. MOTHER'S MAIDEN NAME MARY CROCKETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ML. George Thomas	
17. INFORMANT Route 1 Salisbury, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal insufficiency DUE TO (b) Chronic Pyelonephritis DUE TO (c) ASCIDOS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-27, 1966 to 8-9, 1966 , that (I) (we) last saw the deceased alive on 8-8, 1966 , and that death occurred at 12:30 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Robert A. White Jr.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas F. Wallace		22d. ADDRESS SALISBURY, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8-11-1966	23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park	23d. LOCATION (City, town or county) (State) SALISBURY Md.
24. FUNERAL DIRECTOR Thomas F. Wallace	25a. REC'D BY REGISTRAR Charles Judge		
25b. REGISTRAR'S SIGNATURE Charles Judge			



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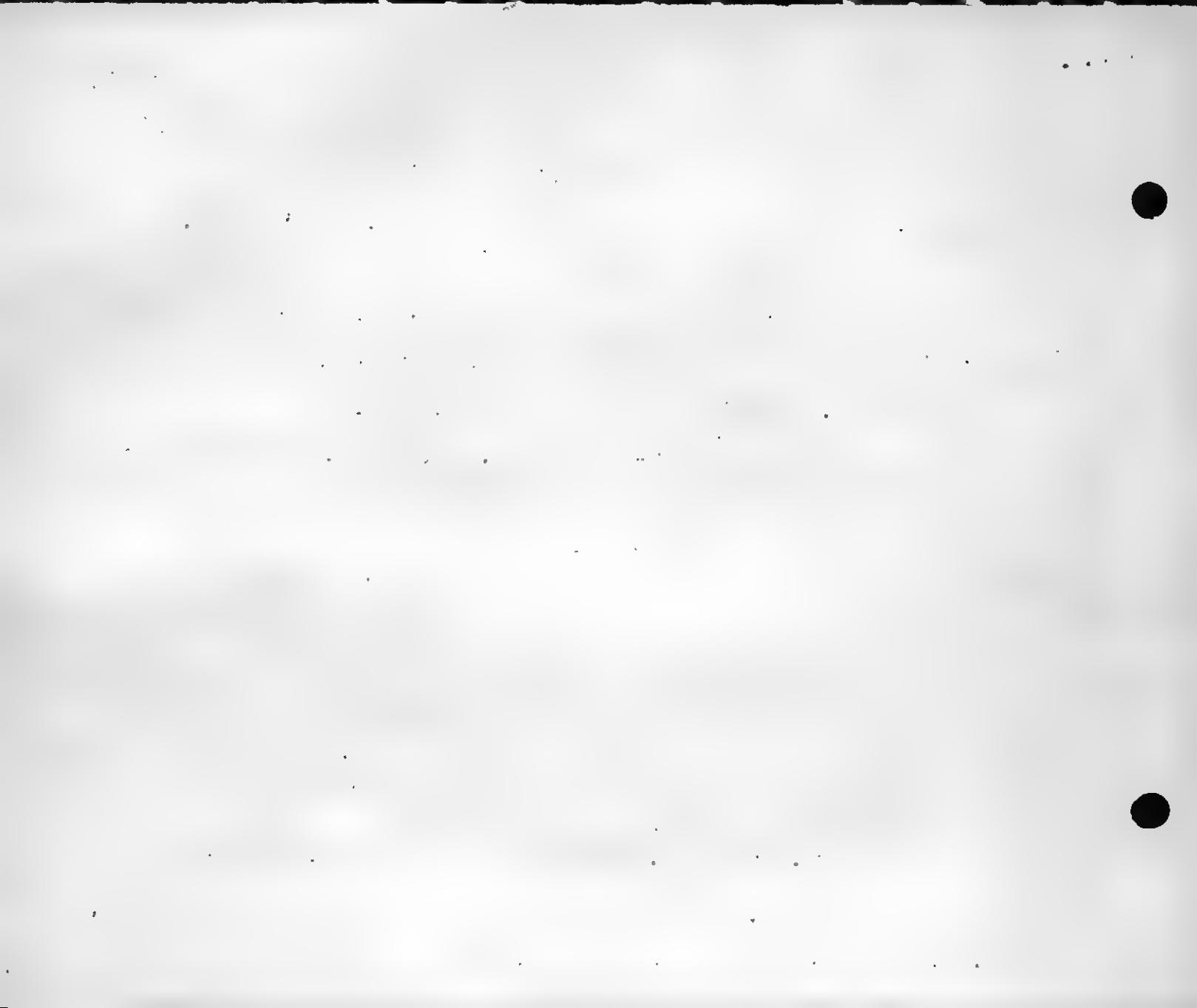
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12057

12054

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		
c. LENGTH OF STAY IN ID <u>July 25, 1966</u>			d. STREET ADDRESS <u>RFD 5, Quantico Rd.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Mayhew</u> Last <u>Toadvine</u>			4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1966</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1891</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>29</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico County Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Theodore F. Toadvine</u>			14. MOTHER'S MAIDEN NAME <u>Annie Hall</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-42-9563</u>	17. INFORMANT Address <u>Mr. William E. Toadvine (Son)</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) (same as #2) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Metastasis to the liver</u> DUE TO (c) <u>Cedencarcinoma of the colon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>2 mo.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>7/25</u> , 19 <u>66</u> , to <u>8/2</u> , 19 <u>66</u> , that (I) <u>was</u> last saw the deceased alive on <u>8/2</u> , 19 <u>66</u> , and that death occurred at <u>3:50 P</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>George H. Henning</u>			22b. DATE SIGNED <u>8-2-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. George H. Henning</u>			22d. ADDRESS <u>Salisbury, Maryland</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug. 5/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parsons</u>	23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>		
24. FUNERAL DIRECTOR ADDRESS <u>HOLLOWAY & COMPANY SALISBURY MARYLAND</u>			25a. REC'D BY REGISTRAR <u>AUG 4 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12053 CERTIFICATE OF DEATH 12055

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 15 <u>BERLIN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>		d. STREET ADDRESS <u>R.F.D.</u>	
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>M.</u> Last <u>Turner</u>		4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 20, 1898</u>
9. AGE (in years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR <u>68</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JESSE TRUITT</u>		14. MOTHER'S MAIDEN NAME <u>ELLA TOWNSEND</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs Jesse M. Turner</u>		Address <u>Ocean City MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asphyxial muscle palsy</u> DUE TO (c) <u>Myotrophic lateral sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/13/66</u> , 19 <u>66</u> , to <u>8/25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/25</u> , 19 <u>66</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Seaford E. Hughes</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>8/27/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	23d. LOCATION (City, town or county) (State) <u>BERLIN WOR. MD</u>
24. FUNERAL DIRECTOR <u>Anna A. Burboye</u>		25a. REC'D BY REGISTRAR <u>John</u> 25b. REGISTRAR'S SIGNATURE <u>John</u>	
ADDRESS <u>Berlin Md</u>		DATE <u>AUG 30 1966</u>	

CERTIFICATE OF DEATH

12059

12056

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN TB 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.				d. STREET ADDRESS Box 37		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Shirley Mae Washington				4. DATE OF DEATH Month Day Year 8 6 19 66			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1919		9. AGE (In years last birthday) 46 yrs		10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY Franklin VA.		11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Johnson				14. MOTHER'S MAIDEN NAME Rosetta Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 217-28-2828		17. INFORMANT William Washington Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Bronchogenic Carcinoma (adeno-carcinoma) DUE TO (c) 10 wks ?							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pathological fracture right humerus - metastatic lesion							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/3 , 19 66 to 8/6 , 19 66 , that (I) (we) last saw the deceased alive on 8/6 , 19 66 , and that death occurred at 3:40 AM , from causes and on the date stated above.							
22a. SIGNATURE A. C. Mitchell M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8/8/66	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.				22d. ADDRESS Deer's Head State Hospital, Salisbury, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/16/66		23c. NAME OF CEMETERY OR CREMATORY Centennial		23d. LOCATION (City or Town) (County) (State) Fairmount Md	
24. FUNERAL DIRECTOR Hutton E. Ward (Ingle) Md				25a. REC'D BY REGISTRAR DATE AUG 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

12057

12060

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When page 3 is removed, carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 16 Days		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.				d. STREET ADDRESS Box 298	
3 NAME OF DECEASED (Type or print) First Middle Last Rhuel E. Watts		4. DATE OF DEATH Month Day Year 8 25 19 66			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-14-02	9. AGE (In years last birthday) 64 yrs	10. IF UNDER 1 YEAR Months Days Hours Min. 6 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Wicomico, Md.	
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME Lena Watts		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) X		16. SOCIAL SECURITY NO. 197-10-9607		17. INFORMANT Address Hosp. Records Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEUKEMIA - DUE TO (b) Hypertensive Crisis & Cerebral DUE TO (c) Cerebral Vascular Disease.					INTERVAL BETWEEN ONSET AND DEATH 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHO-PNEUMONIA					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/9 , 19 66 , to 8/25 , 19 66 that (I) (we) last saw the deceased alive on 8/25 , 19 66 , and that death occurred at 7:25 AM , from causes and on the date stated above.					
22a. SIGNATURE C. H. Winnacott			22b. DATE SIGNED 8/25/66		
22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M.D.			22d. ADDRESS Deer's Head State Hospital, Salisbury		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-29-66		23c. NAME OF CEMETERY OR CREMATORY Sharptown Cemetery	
23d. LOCATION (City or Town) (County) (State) Wicomico					
24. FUNERAL DIRECTOR James B. Klashell			25a. REC'D BY REGISTRAR DATE AUG 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12051

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12058

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (rural)		c. LENGTH OF STAY N 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pemberton Drive Ext. (Esham Farm)		d. STREET ADDRESS RD #3 (RunRidge Rd.)	
3 NAME OF DECEASED (Type or print) First Russell Middle William Last Wells		4 DATE OF DEATH Month August Day 22 Year 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 4, 1918
9 AGE (In years last birthday) 48 yrs		10 IF UNDER 1 YEAR Months 6 Days 18 Hours Min 	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Wicomico Co., Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Vileetus Wells		14 MOTHER'S MAIDEN NAME Florence Parsons	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes War II		16 SOCIAL SECURITY NO. 217-10-2032	
17 INFORMANT Mrs. Nicie Rennie (Sister) Address RunRidge Road, Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bullet wound of Brain DUE TO Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH Accident
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Self-inflicted	
20c TIME OF INJURY Month, Day, Year 12:30 p.m. 8/22 1966		20d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm
20f (City or town) (County) (State) Wicomico Co., Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Earl B. Royer EXAMINER'S NAME (Type) 409 Camden Avenue, Salisbury, Maryland		22. DATE SIGNED August 22, 1966	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Aug. 26, 1966	23c NAME OF CEMETERY OR CREMATORY Farlow Cemetery
23d LOCATION (City or town) (County) (State) Pittsville Maryland			
24 FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a REC'D BY REGISTRAR AUG 24 1966	
		25b REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner *Official along with form PM3. Page 5 may be retained for your files.*

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 14, 17, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

12062

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12059

1 PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE New York b. COUNTY Cornwall on the Hudson c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cornwall on the Hudson d. STREET ADDRESS Peninsula General Hospital e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) HELEN WENCHEL		4 DATE OF DEATH Month 8 Day 25 Year 1966	
5 SEX F	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-18-04
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 62 yrs.
11 BIRTHPLACE (State or foreign country) New York		2 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Casmer Olserky		14. MOTHER'S MAIDEN NAME Balbina Jendrewsky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16 SOCIAL SECURITY NO - -	
17 INFORMANT Louis Mr. Lewis Wenczel, New York (husband)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Acute Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic C. V. Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		22. DATE SIGNED August 26, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		23d. LOCATION (City or Town) (County) (State) Cornwall on Hudson, N. Y.	
24. FUNERAL DIRECTOR Burbage Funeral Home, Berlin, Md.		25a. REC'D BY REGISTRAR DATE AUG 29 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12060											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Pennsylvania</u> b. COUNTY <u>Lancaster</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. LENGTH OF STAY IN 1b <u>Mt. Joy</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>						d. STREET ADDRESS <u>R.D.# 2</u>					
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>AMELIA</u> Last <u>Wenger</u>						4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 10/1896</u>		9. AGE (In years last birthday) <u>70</u> yrs. <u>2</u> Months <u>21</u> Days <u></u> Hours <u></u> Min.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lancaster Co., Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Benjamin Nolt</u>						14. MOTHER'S MAIDEN NAME <u>Amanda Kreider</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>162-38-3229</u>		17. INFORMANT Address <u>Mrs. Naomi A. Nolt (Daughter)</u> <u>R.D.#2 Mt Joy, Pa. 17552</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia - Spasm. negative org.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <u>72 hours.</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> , 19 <u>66</u> , to <u>8/1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/1</u> , 19 <u>66</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/1/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Joseph Fitzgerald</u>						22d. ADDRESS <u>Medical Center Salisbury, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 4/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Groffdale Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Lancaster Co., Pa.</u>			
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u>						ADDRESS <u>SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12064						13441					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Wicomico						a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury						b. COUNTY Wicomico					
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital (D.O.A.)						d. STREET ADDRESS 704 E. Church Street					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last ELWOOD WEST						Month Day Year August 31 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25, 1901		9. AGE (in years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 2 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Horse Groom (Retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Sussex Co., Delaware				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME German West						14. MOTHER'S MAIDEN NAME Martha (unn.)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 213-14-6639A		17. INFORMANT Address Mrs. Nora W. West (Wife) 704 E. Church Street, Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Hypertensive C.V. Disease</i> DUE TO (b) <i>years</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>8-8</i> , 19 <i>66</i> to <i>8-31</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8-22</i> , 19 <i>66</i> , and that death occurred at <i>1:20</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Earl L. Royer</i>						22b. DATE SIGNED Aug. 31 / 1966					
22c. PHYSICIAN'S NAME (Type) Dr. Earl L. Royer						22d. ADDRESS Camden Avenue, Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF Sept. 3, 1966		23c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery		23d. LOCATION (City, town or county) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND						25a. REC'D BY REGISTRAR DATE SEP 8 1966					
						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

12065

MARYLAND STATE DEPARTMENT OF HEALTH

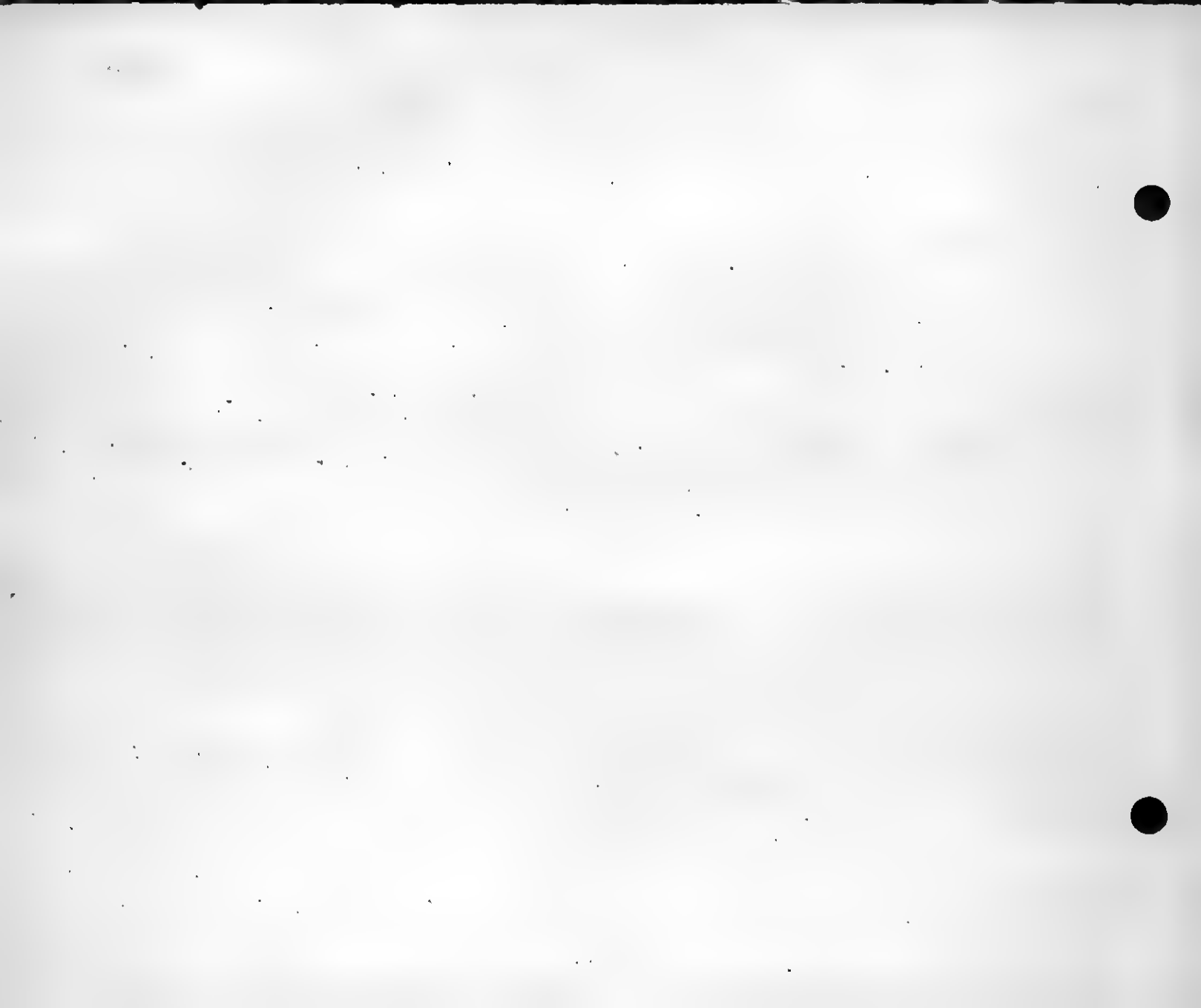
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12061

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John W. White</u>				4. DATE OF DEATH Month Day Year <u>August 20 1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/2/1895</u>	
9. AGE (in years last birthday) yrs. <u>70</u>		10. FINDER 1 YEAR Months Days Hours Min.		11. BIRTH PLACE (County & State, or foreign country) <u>MD. - Wicomico</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (County & State, or foreign country) <u>MD. - Wicomico</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Martha E. Barclay</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>142-12-3330</u>		17. INFORMANT <u>Tsu/White, Nanticoke, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/13</u> , 19 <u>64</u> to <u>8/22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/25</u> , 19 <u>66</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>8/22/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Hebron</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8/25/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nanticoke Cem. Nanticoke, MD.</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DATE AUG 23 1966



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12066

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12062

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS Box # 31		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Sylvester Williams				4. DATE OF DEATH 8-17-66 19 66			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-24-1920 46 yrs	9. AGE (In years last birthday) 46	10. IF UNDER 1 YEAR Months 1 Days 19		11. IF UNDER 24 HRS Hours 19 Min 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY laborer		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALONZO WILLIAMS				14. MOTHER'S MAIDEN NAME REBECCA WALLACE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-16-3226		17. INFORMANT MARION WILLIAMS Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO (b) Laceration of the right brachial artery DUE TO (c) Stabbed during a domestic quarrel.							INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. TIME OF INJURY Month Day, Year A.M. 8-17-66		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Stabbed during a domestic quarrel.		20c. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Home		20d. (City or town) (County) (State) Quantico Wicomico Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.				22. DATE SIGNED 8-17-66			
EXAMINER'S NAME (Type) 109 Camden Ave. Salisbury, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) 8-20-66		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Wetipquin		23d. LOCATION (City or town) (County) (State) Wetipquin Wicomico Md.	
24. FUNERAL DIRECTOR Hilda L. West Address Salisbury Md.				25a. REC'D BY REGISTRAR AUG 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

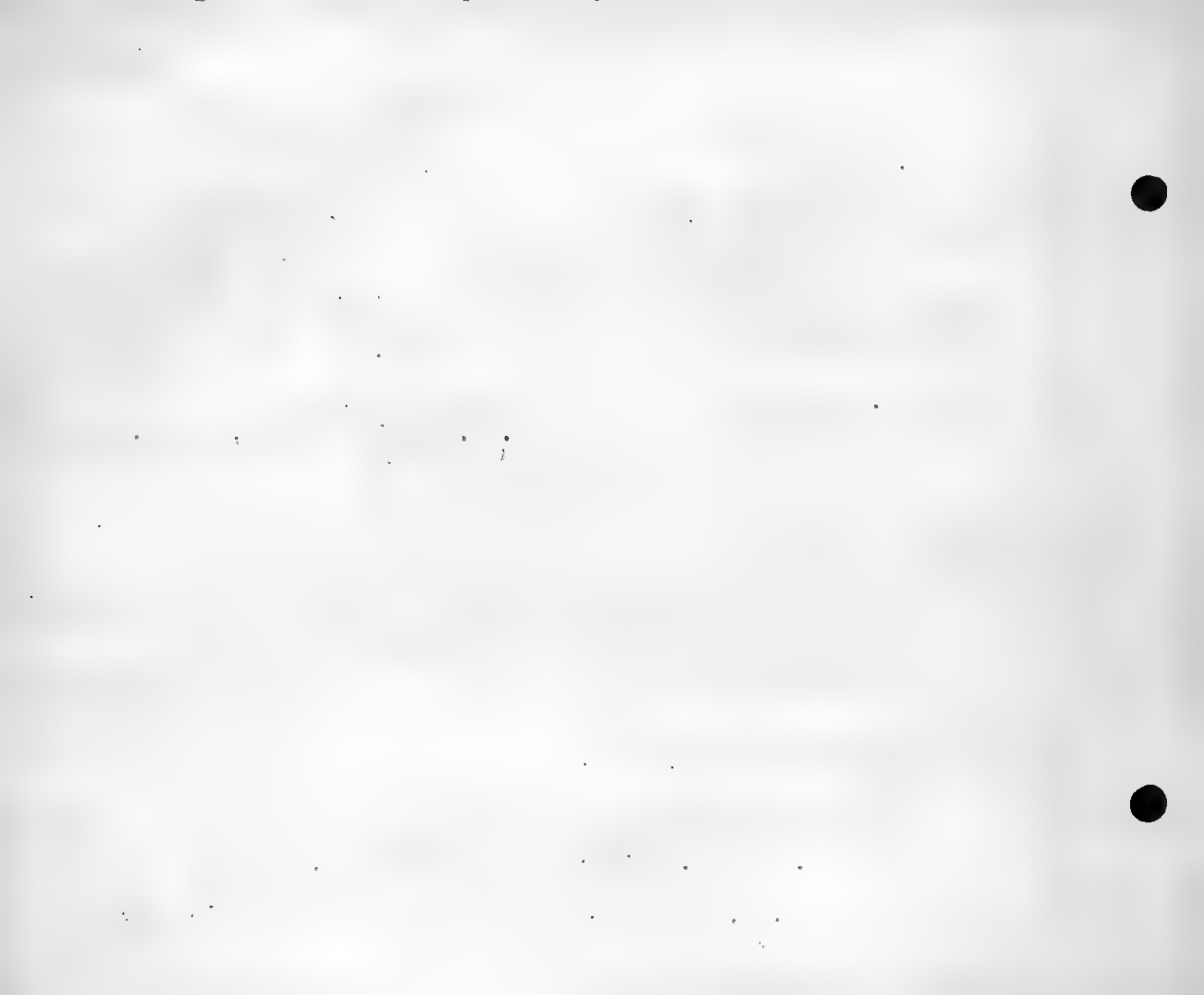
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		e. STREET ADDRESS <u>N. MAIN ST</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Gilbert Williams Sr.</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 23 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 17, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>SELBYVILLE DEL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.M.</u>	
13. FATHER'S NAME <u>D. CASHER WILLIAMS</u>		14. MOTHER'S MAIDEN NAME <u>EFFIE McCABE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-32-862</u>	
17. INFORMANT <u>Mrs W. F. Williams Sr.</u>		Address <u>BERLIN</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion Heart Disease</u> DUE TO (b) _____ DUE TO (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-19</u> , 19 <u>66</u> to <u>8-23</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>8-23</u> , 19 <u>66</u> and that death occurred at <u>7:30</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>William R. Ellis</u>		22b. DATE SIGNED <u>8-24-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/26/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	23d. LOCATION (City, town or county) (State) <u>BERLIN Wor. Md</u>
24. FUNERAL DIRECTOR <u>Anna A. Burdage Berlin Md</u>		25a. REC'D BY REGISTRAR <u>John J. Judge</u> 25b. REGISTRAR'S SIGNATURE	
DATE <u>AUG 26 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <div style="border: 1px solid black; border-radius: 50%; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center; margin-bottom: 5px;">1</div> <div style="font-size: 2em; font-weight: bold;">M</div> </div> <div> <div style="text-align: center;"> <div style="font-weight: bold;">DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> 12066 12064 </div> </div> </div>									
1. PLACE OF DEATH a. COUNTY <div style="font-size: 1.2em;">Wicomico</div> <div style="text-align: right; font-size: 0.8em;">MARYLAND</div>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <div style="font-size: 1.2em;">Maryland</div> b. COUNTY <div style="font-size: 1.2em;">Wicomico</div>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <div style="font-size: 1.2em;">Salisbury</div>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <div style="font-size: 1.2em;">Salisbury</div>			d. STREET ADDRESS <div style="font-size: 1.2em;">914 East Church Street</div>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <div style="font-size: 1.2em;">Peninsula General Hospital</div>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <div style="font-size: 1.2em;">CHARLOTTE BALDWIN WIMBROW</div>					4. DATE OF DEATH <div style="font-size: 1.2em;">August 6 1966</div>		5. SEX <div style="font-size: 1.2em;">Female</div>		
6. COLOR OR RACE <div style="font-size: 1.2em;">White</div>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div style="font-size: 1.2em;">July 10, 1898</div>		9. AGE (in years last birthday) <div style="font-size: 1.2em;">68 yrs.</div>		IF UNDER 1 YEAR: Months <div style="font-size: 1.2em;">0</div> Days <div style="font-size: 1.2em;">26</div> Hours <div style="font-size: 1.2em;">0</div> Min. <div style="font-size: 1.2em;">0</div>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.2em;">House work</div>			10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) <div style="font-size: 1.2em;">Camden, New Jersey</div>			12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME <div style="font-size: 1.2em;">John G. Figgs</div>					14. MOTHER'S MAIDEN NAME <div style="font-size: 1.2em;">Emma Briddell</div>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <div style="font-size: 1.2em;">Mr. C. Ercell Wimbrow, (Husband)</div>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div style="font-size: 1.2em;">Dissecting abdominal aortic aneurysm</div> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <div style="font-size: 1.2em;">Angina</div> DUE TO (c) <div style="font-size: 1.2em;">days?</div>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <div style="font-size: 1.2em;">7.20</div> , 1966, to <div style="font-size: 1.2em;">8.6</div> , 1966, that (I) (we) last saw the deceased alive on <div style="font-size: 1.2em;">8.6</div> , 1966, and that death occurred at <div style="font-size: 1.2em;">M</div> , from the causes and on the date stated above.									
22a. SIGNATURE <div style="font-size: 1.2em;">[Signature]</div>					22b. DATE SIGNED <div style="font-size: 1.2em;">8.8.66</div>		22c. PHYSICIAN'S NAME (Type) <div style="font-size: 1.2em;">Dr. Henry A. Briele</div>		
22d. ADDRESS <div style="font-size: 1.2em;">Salisbury, Maryland</div>					23a. BURIAL, CREMATION, REMOVAL (Specify) <div style="font-size: 1.2em;">Burial</div>				
23b. DATE THEREOF <div style="font-size: 1.2em;">Aug. 9, 1966</div>		23c. NAME OF CEMETERY OR CREMATORY <div style="font-size: 1.2em;">Parsons Cemetery</div>			23d. LOCATION (City, town or county) (State) <div style="font-size: 1.2em;">Salisbury, Maryland</div>				
24. FUNERAL DIRECTOR <div style="font-size: 1.2em;">HOLLOWAY & COMPANY SALISBURY, MARYLAND</div>					25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <div style="font-size: 1.2em;">AUG 9 1966 [Signature]</div>				



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only one is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12069

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12065

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b. COUNTY Wicomico			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital				d STREET ADDRESS 111 Naylor St.			
3 NAME OF DECEASED (Type or print) First NORRIS Middle EMORY Last WOOTERS				4 DATE OF DEATH Month August Day 1 Year 19 66			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-27-28		9 AGE (In years last birthday) 38 yrs	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS Hours 0 Min 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRYWALL INSTALLER CONSTRUCTION		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) DELAWARE		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME FRANK BENJAMIN WOOTERS				14 MOTHER'S MAIDEN NAME GRACE ELIZABETH KNOWLES WOOTERS			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES KOREAN		16 SOCIAL SECURITY NO 221-16-1208		17 INFORMANT GRACE E. WOOTERS - SALISBURY MARYLAND			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Injury <input checked="" type="checkbox"/> , and in my opinion on death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.				22. DATE SIGNED August 2, 1966			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF AUG 4 1966		23c NAME OF CEMETERY OR CREMATORY BLADES CEMETERY		23d LOCATION (City or Town) (County) (State) BLADES DELAWARE	
24 FUNERAL DIRECTOR Watson Funeral Home, Seaford, Del.				25a REC'D BY REGISTRAR AUG 4 1966		25b REGISTRAR'S SIGNATURE Charles Judge	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12070
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
12066

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R.D. #5, Zion Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Ira</u> Middle <u>Watson</u> Last <u>Wright, Jr.</u>				4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 14, 1919</u>	
9. AGE (In years last birthday) <u>47 yrs.</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>		11. IF UNDER 24 HRS. Hours <u>7</u> Min. <u>4</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refrigeration service & repair</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ira W. Wright, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Phillips</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-10-9540</u>		17. INFORMANT <u>Mrs. Mary F. Wright (wife), R.D. #5, Zion Rd. Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Generalized Arteriosclerosis</u> (b) <u>Generalized Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4201</u> <u>hrs</u> <u>hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 18</u> , 19 <u>66</u> to <u>Aug 18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug 18</u> , 19 <u>66</u> , and that death occurred at <u>8:50 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John T. Bulkeley</u> M.D.				22b. DATE SIGNED <u>8/19/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. John T. Bulkeley</u>				22d. ADDRESS <u>Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 22, 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>AUG 22 1966</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12071

CERTIFICATE OF DEATH

12067

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>9 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital, Salisbury, Md.</u>		d. STREET ADDRESS <u>Rt. 1, Box 257 A</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary (none) Yamrick</u>		4. DATE OF DEATH Month Day Year <u>8 18 19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1892</u>
9. AGE (In years last birthday) yrs. <u>73</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>18 19 66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John Gregorwicz</u>		14. MOTHER'S MAIDEN NAME <u>Thersa Gabor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. 	
17. INFORMANT <u>Mr. Charles Gregor</u>		<u>Route 1</u> <u>Berlin, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro- Vascular Accident</u> DUE TO (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Arteriosclerotic cardio-vascular disease with hypertension.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> , 19 <u>66</u> , to <u>8/18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/18</u> , 19 <u>66</u> , and that death occurred at <u>8:40 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Andrew C Mitchell</u>		22b. DATE SIGNED <u>8/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M. D.</u>		22d. ADDRESS <u>Deer's Head State Hospital, Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-21, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Sandtown, Kent Co., Del.</u>	
24. FUNERAL DIRECTOR <u>Thomas F. Wallace</u>		ADDRESS <u>Salisbury, Md.</u>	
25a. REC'D BY REGISTRAR DATE <u>AUG 22 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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100-40-1142-100

[Faint, illegible text and markings on a lined document form, possibly a ledger or record book. The text is mirrored and difficult to decipher.]